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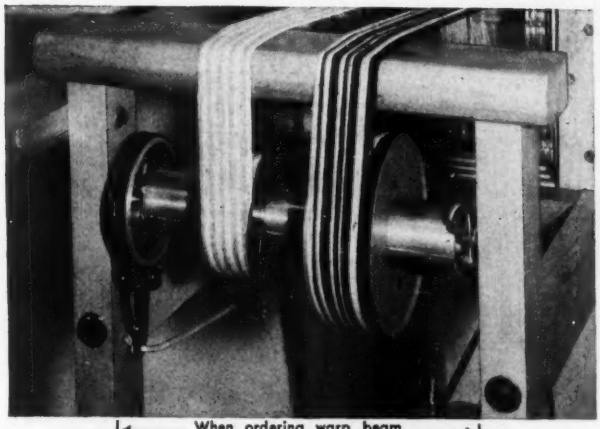

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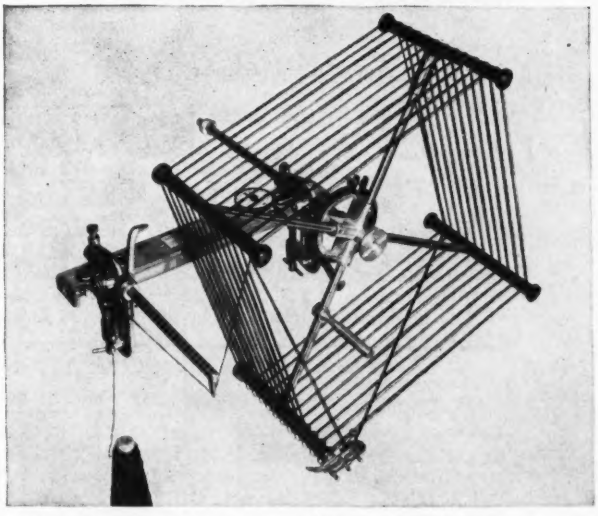
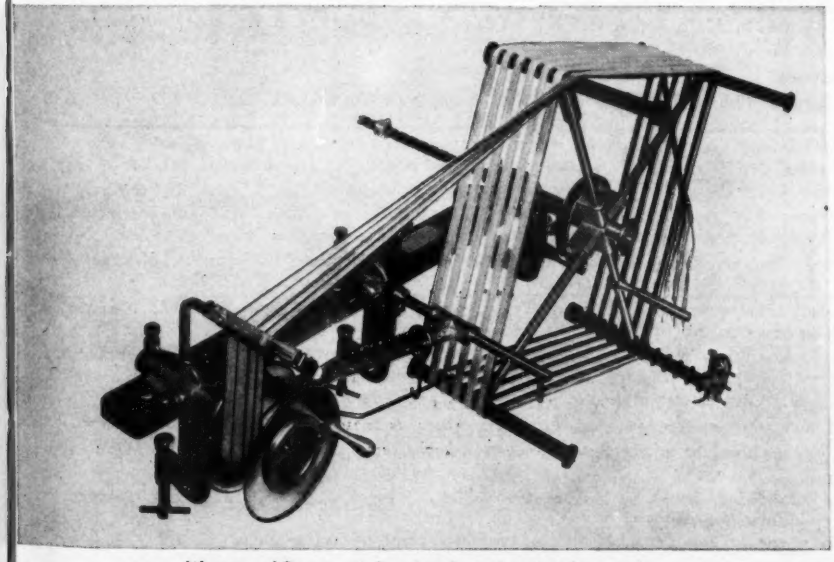


Winding reel from single cone of yarn



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The American Journal of Occupational Therapy

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Conference highlights: 1. *New officers of AOTA.* 2. *Map of state associations.* 3. *New Board members.* 4. *Dr. Fishbein and Col. McDaniel congratulating Col. Robinson on receiving the Award of Merit.* 5. *Some state association delegates.* 6. *Col. Myers, AMSC.* 7. *A conference meeting.* 8. *Two visitors examining the location of OT schools.* 9. *Foreign visitors.* 10. *Board of Management.* 11. *Retiring President, Col. Robinson, and new President, Miss Willard.*

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Digest of Speeches from the American Occupational Therapy Association Conference October 15-23, 1959

OCCUPATIONAL THERAPY FOR THE CHRONICALLY ILL

Attitudes of the Patient and the Therapist

DEAN W. ROBERTS, M.D.

The major characteristic of medicine today is the speed with which it is moving. New drugs, new surgical techniques, new ancillary procedures and above all, new concepts are developing daily. Rehabilitation—the idea of following through with the patient until he can function at maximum capacity—is now fully recognized as a medical responsibility and the members of the treatment team are well defined. With the knowledge and experience that we have now, why are we not doing a more complete job?

The answer to this question is complex. To reach it we should start where all medicine starts: with the patient. We must know who he is and what his problems are before we can evolve ways to meet his needs. In attempting to answer these questions, we must seek new knowledge, correct misconceptions and be alert to the fast moving trends in the composition of our society in general and in the medical fields in particular. We must be willing to reassess and perhaps change our own attitudes toward the patient, and we must try to understand his attitudes toward himself and his disability.

Let us take a look at this hypothetical patient. Is he old or young? Is his problem congenital or acquired? Will he be ill a short time or a long time? Will he get completely well or will he have a residual disability? Will he need occupational therapy? Will there be occupational therapy available for him? The studies undertaken several years ago by the Commission on Chronic Illness have given us definitive answers to some of these questions.

The Commission on Chronic Illness was an independent, voluntary organization, created by the American Hospital Association, the American Medical Association, the American Public Health Association, and the American Public Welfare Association. The purpose of its seven year program was to review and assess the chronic illness problem and attempt to bring order, cohesion, and direction to the many related but unintegrated efforts to prevent and control chronic disease and minimize its disabling effects.

Since it was concerned with disability of any kind whether it resulted from disease processes, trauma or congenital malformations, the Commission on Chronic Illness developed the following broad definition of chronic illness: "All impairments or deviations from normal which have one or more of the following characteristics: are permanent; leave residual disability; are caused by non-reversible pathological alteration; require special training of the patient for rehabilitation; or may be expected to require a long period of supervision, observation, or care."

Progressive control of infectious diseases, improved care of infants and mothers, population changes and other factors have brought about a situation in which chronic illness now accounts for the major share of all serious illness. The chronic disease problem as a whole has looked so formidable that for years the nation was deterred from even starting to work out a solution. Twenty-eight million, the total of chronically ill, has seemed an unmanageable problem.

Now we know that some 23 million of this total are not in the problem group because they are not disabled to the extent that their handicaps call for specialized facilities or services. There remain about 5.3 million in the hard core of the

*Executive director, National Society for Crippled Children and Adults.

severely disabled. Most of this (5.3 million) group, 78 per cent, are in civilian, non-institutional population. They are managing their illness problems in their own home or the homes of relatives with occasional short term admissions to general hospitals. Only 22 per cent are in institutions for long term care, half of them in mental hospitals.

Old age formerly was erroneously confused with chronic illness—the term even being used interchangeably in much of the literature of 15 years ago. Now, it is more generally recognized that chronic illness affects all age groups. Of the 5.3 million severely disabled chronically ill, 49 per cent are in the productive period between ages 25 and 64.

Thus we are dealing not primarily with the geriatric patient, who for better or worse, has made his mark in the world, but with large numbers of men and women who have been stricken during their productive years. These figures include the wage earner, the housewife, the mothers and fathers of our next generation. This fact has important implications for our social and economic welfare. It offers a serious challenge to the members of the treatment team who are concerned with keeping these people in circulation by helping them remain self-sufficient, contributing members of society.

Keeping a person in circulation encompasses more than concentration on physical competencies. Attitudes, favorable or unfavorable, influence the chronically ill patient, and this often spells success or failure in a vocational endeavor. The occupational therapist must constantly be aware that he is dealing with a mind and a body, and how they perform is of great importance. The factors which must necessarily be analyzed when vocationally appraising a patient or client are personality, physical capacities and performance. The information which is accumulated on the abilities and capabilities of a patient becomes valuable data for the vocational counselor in arriving at a vocational objective with the client.

The occupational therapist can, in most instances, gain valuable information by an awareness of the following factors influencing attitudes: (a) The extent to which a shop environment and work task provides opportunities for self development and for the realization of personal goals. (b) The extent to which the work task provides satisfactory challenge to the abilities and interests of the patient. (c) The extent to which the work task provides sources of annoyance.

In part, the work of the occupational therapist is one of appraising the attitude of the chronically ill and providing satisfactory tools for creating more favorable attitudes. For successful achievements in the vocational area, motives, skills and attitudes are equally important. Healthy attitudes can be fostered by the occupational therapist in the medical climate when treating a disability as well as in the vocational climate when appraising abilities and capabilities.

Absorption in a task indicates a favorable attitude toward work and the surroundings. The unfavorable attitude is often reflected in irritability, distractibility and complaints.

Most chronically ill persons must be considered potential candidates for employment in our labor market. Healthy vocational attitudes can be developed, determined and maintained by the intelligent use of the professional skills of the occupational therapist. Keeping people in circulation is the challenge which the labor market places on the field of health, and our attitudes along with our patients' must be firm and healthy.

The Commission on Chronic Illness made a survey of all patients in general hospitals in Maryland, to determine the number of long term patients in general hospitals, their characteristics and the hospital services they had received. Long term patients were defined as those who had been in the hospitals 30 days at the time of census. It is expected that most patients who remain 30 days will remain a substantially longer period of time, and at discharge will either need some type of follow-up care or be left with some residual defect or impairment. On the basis of time alone, this is comparable to the 30 per cent figure suggested by your association as the number of patients in a general hospital who could profit by some form of occupational therapy.

Some of the findings of this study should be of interest to those occupational therapists whose job it is to convince general hospitals that OT is needed for their patients. Nearly one-eighth of all patient care is devoted to patients who have already spent 30 days in the hospitals. Half the patients in general hospitals have been there less than one week and nearly three quarters less than two weeks. The remaining patients were distributed in decreasing numbers over the longer duration: 2.6 per cent had been in the hospitals three months or more and one per cent had been there six months or more

Attitudes toward long term illness are changing as its nature and the needs of its victims are better understood and better treatment methods are known. Fortunately, during the last quarter century, the rate of change has been accelerated. Previously, misconceptions were so widespread that attitudes constituted the single most important block to progress. They are still impediments, for much chronic illness is painful, ugly, depressing and costly.

An appraisal of changing attitudes,, however, reveals what kinds of ideas have been modified

and provides some measure of what still needs doing. Only a few years ago chronic illness was commonly regarded as hopeless. Now it is well known that many persons who are seriously disabled can be restored to comfortable, happy usefulness.

A short time ago, most chronic illness was regarded as progressive, if not hopelessly static. Now we know that the progression of the disease can often be interrupted and that its course has many ups and downs. No matter what his diagnosis, every long term patient has in common one major need: to be looked upon as an individual, whole person. The urgency of this need was made clear by the National Conference on Care of the Long Term Patient; one report after another reiterated that the long term patient needs to be identified as a person and not as a disease or a focus of a program, and needs to be considered at all times as an individual with specific relationship to his family and the community.

The impact of chronic illness on the patient differs in important respects from that of acute illness. In acute illness, where the onset is sudden and the course of illness usually brief, the patient and the family often have sufficient resources — financial and emotional — to cope with the situation. However, in chronic disease the onset is insidious and by definition the course of illness is long. Families are drained emotionally and economically, and associated with all serious chronic illness are important dislocations in relationships between the patient and his family and with society. In treating acute illness it is possible for the doctor to provide virtually all the care, with some assistance in the more severe cases from the nurse. In chronic disease, much more is needed than the doctor's and nurse's skill.

The variety of services and facilities useful to long term patients illustrates the complexity of their needs. At some time in the course of their illnesses, many long term patients while at home or in a general or special hospital or home for the aged require several of the following services: medical supervision, drug and diet therapy, X-ray therapy, surgery, psychiatric treatment, dental treatment, medical social service, bedside nursing, physical therapy, appliances, training in use of appliances, occupational therapy, training in self-care, vocational training and counselling, education, sheltered work at home or elsewhere, personal adjustment training, home-maker service, transportation, financial aid, assistance in providing adequate housing, foster home care, legal aid, convalescent care under medical supervision, custodial care, and counselling to modify the family's and the patient's attitude toward chronic illness.

As this list indicates, the long term patient needs, in addition to definitive medical care, the kinds of services that will restore his morale, keeping him intellectually and emotionally in the stream of life. Not all long term patients will need all these services, but most will need several. Social work, occupational therapy, physical therapy, rehabilitative and counselling services — all of relatively little importance in acute illness — are of prime importance in the care of the chronically ill.

Another characteristic which frequently differentiates between acute and chronic illness is the role played by the patient in the recovery process. In acute illness, such as pneumonia or appendicitis, the role of the patient is a relatively passive one. By use of antibiotics and surgery the patient is cured by the doctor. All the patient has to do is to submit to the treatment. Not so in most chronic illness. If there is to be success the patient must participate very actively in the program for recovery. Successful management of such diseases as diabetes, peptic ulcer, tuberculosis, arthritis and heart disease requires full appreciation of the problem by the patient and his active participation with the team in the treatment program.

Not only must the long term patient adjust himself to the realistic limitations imposed by his disability, he may be called upon to modify his conception of himself as a useful human being able to carry his own weight and make a contribution to his world. Often he is regarded by himself and others as inferior not only with respect to his particular limitation but as a person. He may feel shame, inferiority, even worthlessness to a degree which his physical condition and his residual potential do not justify, and which does not generally accrue as a concomitant of acute illness.

Disability may have overtaken him almost instantaneously, for example, following an accident or a stroke. In addition to prompt and adequate medical care he will usually need help in adjusting to this sudden interruption in life as he expected to live it, and in assessing his strengths for making the best of a situation which ultimately may not be as bad as he at first thinks. If illness or injury leaves him with a permanent impairment, the occupational therapist may need to help him find new ways of satisfying his old interests, new ways in which to be useful.

Other needs for care arise from the nature of chronic illness. In contrast to acute illness, which is characterized by rapid change, chronic illness may progress or subside so slowly that change can be measured only over the weeks or months or years. Change may be so gradual that it is easy to believe there is no change. Yet one of the fundamental features is that exacerbations and remissions do occur — and care and treatment must be modified accordingly. Moreover while the change in the disease or impairment itself may

occur slowly, or not at all, the patient's reactions and responses to his condition are likely to be in a fairly constant state of flux. This, too, has important implications for the occupational therapist who must be alert and flexible.

The professional education of the occupational therapist places equal emphasis on the physical and psychological factors of illness. He is taught to understand the patient as a sensible human being who reacts normally to an abnormal situation, and he is trained to deal with the patient's physical and emotional abnormalities. In caring for the chronically ill patient he will increase his knowledge about normal reaction to illness and will broaden his horizon regarding the place of a disability in the patient's total life pattern. His efforts may result in increased skill in a weakened hand, or may provide a hobby for someone who is bedfast. On the other hand, he may find that an equally important contribution is to arouse in a discouraged handicapped homemaker the desire to solve her own housekeeping problems.

Most occupational therapists work in hospitals, rehabilitation centers, nursing homes and other institutions. Obviously many of the chronically ill are to be found there. However there is a trend away from hospitals that could well be recognized by the occupational therapy profession.

There has been relatively too much emphasis on the construction of beds as a solution to the problem of chronic illness. It is true that construction of additional facilities, particularly for rehabilitative services, is needed, but more and more beds for long term care will not solve our basic problem. Administrators of mental, chronic and general hospitals verify the presence in institutions of large numbers of patients whose care requirements could be better met in the home if nursing services and other limited technical services could be made easily available to them.

One of the most constructive steps a community can take is to provide a generous measure of services which will enable families to care for their members at home. Each community will need to determine for itself what services should be offered and by whom. The most frequent and perhaps the most important is the visiting nurse offering bedside care, whether under public or private auspices. Other important home services would include occupational therapy, social case work, physical therapy, homemaker service and the loan of bedside nursing equipment.

Shortages characterize all health personnel groups. In long term care, shortages in these categories are probably the most acute; general practitioners; psychiatrists; specialists in pulmonary medicine and in physical medicine and rehabilitation; public health physicians; nurses, particularly the public health nurse giving bedside care, and the practical nurse; trained attendants; medical and psychiatric social workers; occupational, physical and speech therapists; and vocational counselors. Most of these shortages are not primarily due to insufficient professional schools. The schools which offer training for most types of the needed personnel report vacancies. Ways must be found of attracting more young people into these occupations. Not only must the numbers be increased but educational programs must be revamped to produce personnel interested in and equipped to care for long term illness.

Chronic illness has emerged as the major health problem facing the nation. It is the long term patient who is producing the greatest strain on hospitals and other medical facilities. Communities are not now geared to cope adequately with chronic illness. Experiments are being conducted in new and improved patterns of patient care. Among these are organized home care programs and progressive patient care as proposed by the United States Public Health Service.

In many parts of the country nursing home care is being substantially upgraded by licensure, regulation, education and federal aid in construction of modern, non-profit nursing homes. Organized medicine is demonstrating a real concern and interest in the quality of care in nursing homes.

It is ironic that medical progress has contributed to so large a degree in accentuating the problem of chronic illness. The conquest of acute illness requires the individual to live on to develop chronic illness. Medicine has been more successful in preventing death from tuberculosis, prematurity, paraplegia and rheumatic fever than in prevention of the disabilities associated with them. As a result, the numbers of cases with long term illness and disability increase and apparently will continue to increase.

By reason of the philosophy of the profession and the specific training, occupational therapists are particularly well equipped to work constructively with both the physical problems and the problems of attitude and motivation of those who have prolonged disability. Of these two types of problems, that of the pathological and disabling attitudes of the patient is both more difficult and more important to deal with effectively than the simpler physical disabilities. It is here that occupational therapists will find their greatest challenge.

EVERYDAY PRACTICES IN ORTHOPEDIC REHABILITATION

CARL D. MARTZ, M.D.*

The purpose of this discussion is to pinpoint opportunities and responsibilities in an area of traditional service that has become somewhat complex and confused in recent years.

In consideration of this ill-defined term, "area of rehabilitation," we could clarify our understanding by a preamble—or as the politicians would say, a platform—expressing our obligations to:

Realize that the rehabilitation of the disabled has been one of our primary activities since our inception as a specialty. This process begins in every office, clinic or bedside consultation ending only when the patient has achieved the fullest obtainable participation in the normal process of living.

Recognize the many fine individual agencies at work in the field, encourage them, guide them, use them and inform patient and public alike of their many services.

Serve the disabled by diagnoses, training, bracing and surgery so that every possible defect, deformity and disability is corrected as completely and promptly as is consistent wtih realistic rehabilitation goals. For residual remains, we should evaluate the degree and stability of that disability and accurately define and interpret the medical feasibility of further training, employment, and self care.

Distinguish the residually handicapped for whom independent function, training and employment are not feasible and secure for them proper homebound or custodial care with periodic medical review.

Relate our work to the whole field of rehabilitation and integrate our contribution with that of other therapists, physicians, educators, employers, labor leaders, underwriters, governmental agents, ministers and recreational workers.

Cooperate directly with all concerned in giving realistic person-to-person guidance and assistance.

REFERRAL AND CASE FINDINGS

Handicapped persons may come directly to the office or clinic; thus, the first contact is made without difficulty. However, the initial case findings often occur in the office of the welfare worker, the visiting or school nurse, or the voluntary agencies. Background material referable to the patient then becomes available before the first contact. This material should be assembled and studied. Not infrequently, the patient will have been seen by others. This represents an opportunity for cooperation and reinforcement with colleagues and agencies; or contrariwise, may mark the beginning of duplication of service and misunderstanding. The patient's choice can and should be honored within the limitations provided by financial sponsorship and the service facility. This may be difficult, but every effort is most worthwhile for patient morale. The nature of a given case shall determine the role of team play by physician and associates. Such team work may be of great help or may result in wasted time, energy, talent and money for all concerned.

Registration, records and progress reports of the handicapped person wherever he receives care should be part of his running record so that care can be adequate, prolonged, consistent and remitting toward reasonable goals.

EVALUATION

Evaluation of a handicapped person may sometimes be carried out quite adequately in the doctor's office or at the hospital clinic. More often, the contributions of the nurse, physical therapist, occupational therapist, social worker and other physicians prove extremely important. Physical fitness evaluation, muscle analyses, functional activity tests and critical review of braces and appliances should, from the beginning, point up definitive targets, objectives or goals and, as early as possible, these goals should be brought to the mind of the patient, his family and his sponsors.

Hopelessly impossible goals rob the patient of his own self-respect, frustrate all who work with him and waste vital resources of all concerned. It is here that some of the greatest frustrations to doctor, patient and co-worker alike occur. More particularly, the morale of the patient suffers if a bedfast or chairfast patient is promised or reassured that he will walk freely and work at any job of his choice. Trips to and from various meccas, parades of do-gooders and well-wishers cannot change the realities of a situation. There should be no evasion by the orthopedist of his responsibility to evaluate objectively and interpret carefully to all concerned the problem and the potential in so far as he can anticipate the end point. This is important in static as well as in progressive disabilities.

Various forms available are perhaps too complicated in this regard and endless batteries of tests are available. More and more we like to

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think of these batteries as tools for expert observers and rely upon simple judgment statements by therapists, psychologists, nurses, teachers and work counselors. It is here that a good social service worker can helpfully bring together the contributions and observations of many.

PRESCRIPTION

The prescription for physical and occupational therapy is the traditional responsibility of the orthopedist. He has been patron, guide, counselor and sponsor of physical and occupational therapists through the years. The problem of body mechanics, muscle re-education, gait training, hand training and assistive devices are his stock in trade. It is difficult to see how or why he should relinquish these vital considerations to others. Increasing emphasis should be placed on training and bracing programs because improvements in materials, methods and understanding are occurring almost daily.

The prescription for therapy must be direct and in sufficient detail to guide the therapist in an understanding of the problem, the patient's potential, and how long it will take to reach a reasonable goal. It should specifically describe the limitations to treatment, duration and the re-examination date. The choice of technique often requires personal discussion, combined examination, demonstration and observation of the patient both at the time of initiating therapy, at progress intervals and at the time of determining the end point.

CLINICAL REVIEW

The clinical picture of the patient will determine whether or not his progress review should be carried out in the office, in the therapy department, in the brace or limb shop, or before a clinical conference group. Problem cases are greatly aided by an appearance in a clinical conference where free discussion by the doctor, his co-workers, patient, parent and sponsors is encouraged. A learning process occurs in which contributions may arise from all quarters and understanding develop in all concerned. Reinforcement of morale of a discouraged patient, parent or therapist is a frequent by-product. Observation at regular intervals of a similar group of patients by the staff, by the patients and families is always helpful. Project clinics for amputees, club feet, scoliosis and cerebral palsy carried on over a period of years have been a most helpful arrangement. End result clinics have been most revealing. Such conferences can be overdone and there can be confusion and waste of time and energy. More often, such group conferences are of great value both to the case in hand and in a teaching sense. It is at these sessions that students of medicine and nursing and of the special therapies best learn the fundamentals which will guide them in their later work. Its discipline benefits the senior practitioner as much as a junior resident and student.

THERAPEUTIC GOALS

Not enough has been said or done about reasonable objectives and goals in the care of handicapped persons. It is natural to avoid the problem but with diagnostic appraisal comes the responsibility for accurate prognosis. We are concerned with the correction of deformity, the preservation and restoration of motor functions of the patient as well as determining the general expectancy in terms of posture, gait, locomotion, hand use and everyday functions of self-care, work and play.

Rehabilitation and hospital centers, trade schools and sheltered work shops have clearly defiined functions. Cooperative endeavor and frequent communications are needed so that duplication of staff facilities and service to patients will not occur. It is difficult to conceive of a truly modern hospital without a rehabilitation point of view, and more and more their out-patient facilities are being made available to those who need them.

As soon as possible after initial evaluation, goals should be established and shared with patients and staff alike. These must not be too high nor too low. Their determination presents both the art and science of the good physician and therapist.

The role of intensive training, of home programs and of occasional out-patient review will depend upon the problems and circumstances of the patient but, for the most part, short term in-patient programs can be blended with long term home programs to achieve the desired result. It is extremely important that end points be determined when the greatest possible achievement of the patient compatible with his previously determined goals has been realized and that this be recognized by all. Thereafter, his review by the doctor and the therapist shall be in regard to the maintenance of his performance and the addition of any new device, appliance, training or surgical procedure which might be of benefit. Any improving power or skill or increasing deformity or disability will be recognized and treated. Weight gain, age, wear and tear on appliances, all of these alter the ability of patients and will be noted.

General health must not be forgotten. The family physician must not only be made aware of the orthopedic aspects of the patient's problem, but should be given the specific responsibility for general health care. His contribution to the orthopedist is vital in terms of the evaluation and interpretation.

Long term review of handicapped persons is most desirable from the point of view of the

orthopedist, the educator, the employer and social worker. We do not know enough of the pattern which individuals pursue with their various types of disability.

DISABILITY EVALUATION

More objective appraisal of disability is being requested. Guiding principles are slowly evolving and standards are being established. Social awareness and consciousness is coming to bear on the plight of the irreparably handicapped individual. Review of his situation, the correction of any increasing deformity, the improvement, when possible, of any increasing dysfunction remain the responsibility of the orthopedic surgeon and his caseworkers. Whether the care of the patient is custodial or whether the patient is striving to remain self reliant, he cannot be neglected. The entire community bears responsibility in this rehabilitation process which capitalizes upon the resources and potential of all who live around and above a handicap.

SUMMARY

This then would summarzie our opportunities and our responsibilities:

1. The care of the crippled is our professional obligation and responsibility.
2. We must establish realistic goals and strive for their attainment.
3. We must make intelligent and honest use of all our skills, our tools and supporting personnel.

Furthermore: We should prescribe prosthetic devices, appliances, treatment programs and surgical procedures only when we understand their functions and their limitations.

We cannot forsake our professional birthright or neglect our professional heritage. The orthopedist must continue responsible leadership in the areas of physical and occupational therapy, in brace and limb-making and in surgery.

As he cooperates with other disciplines in the field of rehabilitation, new techniques will be discovered and new horizons will unfold to benefit the handicapped in treatment, appliances, employment, residential housing and custodial care.

LEGAL ASPECTS OF OCCUPATIONAL THERAPY

CHARLES U. LETOURNEAU, M.D.*

The legal aspects of occupational therapy are not too well developed because the profession is a young one. To establish a jurisprudence it takes a lot of people to get in trouble over a period of years before one can tell what the law would say under the circumstances. Oftentimes the view that we take of an occurrence is not quite the view that twelve good men and true, sitting in the jury, might take of it.

You get unusual reactions sometimes when something that seems perfectly clear and logical to you doesn't seem that way at all to people who are sitting on the other side of the fence. Therefore I would like to mention certain principles that you ought to bear in mind when you practice your profession. As citizens we have obligations not to cause each other any harm either willfully, neglectfully or through want of skill. These are the three main things. A willful act, of course, would be a criminal assault on somebody. This would not happen too frequently to occupational therapists unless you got angry at a small child or a mental patient who did not quite react the way you wanted him to and struck him so as to hurt him.

Neglect might occur sometime when you have too much to do. If you are trying to supervise too many patients at once, you may have to neglect one to look after another. A jury would not consider whether or not you were overloaded with work. They do not care about this.

Finally, through want of skill, you might undertake some task for which you had not been well trained or for which you were not suited. There are certain tasks in occupational therapy which do require a certain amount of knowledge and skill.

As a professional occupational therapist you have very much higher duties because you are so much more highly qualified than the average citizen. If you are ever attacked in a court of law for want of skill or negligence you will be judged according to standard conduct of an occupational therapist. The attorneys will bring in expert testimony. They will ask other occupational therapists a hypothetical question, such as "What would you have done under the circumstances?" Upon what these people say may depend what the jury thinks.

The standard of care is what a prudent, sober, knowledgeable occupational therapist would have done under the circumstances. What that is you never know until you are standing there facing the jury and listening to your colleagues say what they would have done.

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You should establish what your role is in the care of the patient. Legally, we can divide the care of the patient into four distinct phases.

The first stage, which is that of *investigation,* is a fact-gathering stage where one might take the patient's temperature, blood pressure, observe his manner of speech and his behavior. All kinds of people gather facts: social workers, laboratory technicians, occupational therapists, registered nurses, internes and so on. These are all facts that are observed; they are occurrences that you have observed with your own five senses. You have seen them, heard them, felt them.

The second phase is the conclusion drawn from these facts. This is called the *diagnosis.* To all of these facts, a licensed doctor of medicine applies his knowledge, his skill, his training, his background and generally his judgment to come to a conclusion. He says, "From what I see and from the facts that have been gathered, I judge that this patient has cancer." Then he makes a prognosis, an educated guess of what will happen.

Having identified and concluded that the patient has a certain condition, he enters into the third phase: what to do about it. This is called *prescription.* Here again the medical doctor draws upon his knowledge and experience and says, "From what I know, the best thing to do is to give this patient a certain drug or a speical diet, or massage, or corrective exercises or occupational therapy." He prescribes treatment.

Finally, we have the fourth phase, which is *therapy,* where the prescriptions of the doctor are carried out, be it by an RN, PT, OT or pharmacist.

Phase one and phase four are within your province. You may gather facts and you should record them and make reports on them. In stage four you should administer the therapy that has been prescribed for the patient. But you may not carry out phase two or three. You may neither diagnose nor prescribe. Why? It isn't because you aren't competent to do it, but the law just does not allow you to do it. A medical doctor is a person who carries on a healing art with the permission of the state. He has a license, and this license entitles him to diagnose and prescribe. He can also do the investigation and therapy if he chooses and sometimes he does so.

How can you get into trouble in occupational therapy? I have read some of your reports and looked over some of your case records. I am often impressed with the number of times that an occupational therapist (and other professional people as well) attempt to diagnose. Especially in mental hospitals where an occupational therapist is tempted to tag a label on the patient's behavior. This is not within the purview of your duties. You are often forced to prescribe — the physician who sends you the patient probably knows less about what he wants done for the patient than you do. So he may say, "Use your own best judgment." Again, this might be interpreted as a transgression on the practice of medicine. You could ask me, "In this circumstance, what should I do?" I can't tell you what to do except to use your own best judgment for the benefit of the patient. If you do this you can not go far afield.

There are several things which you in your professional capacity, working in a hospital, have to do. In addition to being professional people, you also are an arm of administration. Whatever the hospital's duties are to the patient, these also are your duties.

The first duty of the hospital is the custody of the body of the body of the patient. The custody of the patient includes protection of his person — that is, of his physical body; second, protection of his property — that is, whatever he has around him; and third, the reputation of the patient.

As far as his property is concerned, you must see to it that none of his small valuables are lost. As far as the reputation of the patient is concerned, you should not talk abroad about the patient and his behavior except as part of your professional duties. You can discuss these with the physician who treats the patient and with other occupational therapists and perhaps with the social workers, but beyond that with *nobody.* You may refer to these cases in some abstract way in meetings such as this, provided that the patient is not identified.

The physical body of the patient has to be protected against two things. The first is infection. Today we are becoming more and more concerned with the staph infection — the golden villian — and we are beginning to take another look at the sanitation of our hospitals. This includes sanitation of your department.

The second is injury. You are responsible for protecting the patient against defects in accommodations. By accommodations I mean that you must see that your department is in a good state of repair, that there are no loose boards or plaster, that the floor is not too highly polished, and generally well maintained. Second, the equipment — you must protect the patient agains defective equipment. This is especially so where you are having the patient use the equipment. You have a double duty to test out this equipment beforehand and see that it is safe for the patient to use.

This is in addition to the judgment you and the physician should use as to whether the patient should be allowed to use this type of equipment. For example, I cannot see you allowing a six year old mentally retarded child to do any fretsaw work. This would be an error of judgment.

But if you have a piece of machinery which is not functioning properly and the patient gets hurt, this is part of your duty. There was a case in point involving an X-ray machine. The head fell off this X-ray machine and landed on the face of a fine-looking girl who was having an X-ray taken of her sinuses. She was disfigured. It was discovered that nobody had done any maintenance on the machine for three years and that a simple wing-nut had come loose. Of course the weight holding the head came loose and the equipment fell.

You are responsible for the supplies you give to the patient which may injure the patient. You have a responsibility also for other things like personnel. Never assign an unqualified person to a job that is beyond his capacity. If you do, this becomes your responsibility.

I would like to pass now to your duties to the physician because, in addition to the patient, you also have a duty to the doctor who is treating him. Some of you either do not give enough information to the physician or may be so garrulous that perhaps he will never get around to reading the report. You should simply report observations of facts. Do not report conclusions. This is the best way I know of getting the physician angry with you and also it is a liability in a court of law in the future. Therefore report facts, not conclusions.

Second, if you carry out the doctor's instructions in his physical presence, where he is watching you and guiding you, then he must take responsibility for anything that goes wrong. But when you are not under the physician's supervision, and the orders and instructions are quite clear, then you will assume liability for your own actions. Do not do more than his instructions call for.

Then, there is the matter of loyalty to the physicians. You must always refrain from making any derogatory remarks about any physician. This also goes for nurses and other occupational therapists. Occasionally persons probably don't notice it and don't do it deliberately, but I have heard more than one person say, "Him? I wouldn't let him operate on my dog!" It isn't that you mean anything wrong by it, it is just that you wouldn't let him operate on your dog. And the people who listen to this may not take the same connotation of your remark. The fact of the matter is that you can be sued for libel or slander. Libel is a written derogatory remark; slander is a spoken one.

Then, you have the duty to keep your knowledge current. A physician has a right to expect that if you are an occupational therapist you are up to date on the latest forms of treatment and that he does not have to draw pictures for you or go into lengthy explanations.

What about your duty to other occupational therapists? You have a duty to your superiors. If you are working under the supervision of someone in the department, then you have a duty to carry out the instructions and general policies which he or she lays down.

If you are the supervisor yourself, then you have a duty to supervise the work of your subordinates and especially the work of students. There was a case involving a supervisor where one student nurse gave the wrong injection to another student nurse as a result of which the latter lost her arm. The supervisor was held responsible and not the student nurse because she had a duty to check the solution which was injected.

The next duty you have is to the administration of the hospital. All of us work as a part of a coordinated body. Number one, of course, is the keeping of adequate records. The administration has a right to know what is going on in the hospital. Otherwise, how can you administer a place if you don't know what is happening. After you talk to some social workers and some occupational therapists, everything is just so confidential that even the doctor shouldn't see it. This is carrying things to extremes. You have to keep whatever records you are ordered to keep — you have to make reports promptly. These are legal duties. If anything goes wrong and there is no record of it, the administration will have to answer.

You must uphold the law. It is not often that you might have to define transgressions of the law in your department, but it could happen. If you know that a physician, for example, is going to perform a hazardous procedure on a patient without a proper written consent, then you have a duty to report this to the administration and to stop it, unless it is a matter of emergency.

Upholding the regulations is a must. Nobody likes to be a scab, yet you, as an arm of administration, have a duty to see that the fire regulations, for example, are respected. If you are working with plastics that are highly volatile or inflammable materials and there is a big sign that says "No Smoking," it is up to you to see that the sign is observed and to report infractions to the administrator.

One more thing all of you will ask — should an occupational therapist carry insurance? The answer is "Yes, you should." All professional people who have anything to do with the use of professional judgment where they may possibly hurt a patient should carry insurance. You can get the details from your own association.

LEGAL ASPECTS OF MEDICAL RECORDS

G. MARGARET GLEAVE, O.T.R.*

RECORD WRITING

Of equal importance with the treatments you give your patients are the records you keep and the reports you make. Good medical records not only contribute to the professional care of patients but also reflect the quality of professional care given.

There is considerable apathy in the profession of occupational therapy toward the legal aspects of medical records. Probably rightly so, because it is extremely rare that an occupational therapist is called into court to substantiate a claim.

Yet if occupational therapy is to justify its rightful place in the total treatment program of the sick and injured in the various fields of medicine in which it functions, good records and reports are necessary. These records and reports must become an integral part of the institution's medical records to be of value.

Medical records are kept to provide administrative control of the institution's program, contribute to the professional care of the patients, aid and advance the science of medicine through research, and comply with laws and serve in defense of a claim. These generally accepted purposes apply to departmental records as readily as they do to general medical records. The ability to record and report on an individual treatment and on a total treatment program is, therefore, basic for the effective operation of any occupational therapy department.

LEGAL ASPECTS OF MEDICAL RECORDS

The information that is kept in medical records and reports is of such a nature that a brief resume of the legal aspects is in order. All medical records are the property of the institution. The institution, as owner of these records, is legally and ethically obligated to protect them. The *Code of Hospital Ethics* adopted by the American Hospital Association and the American College of Surgeons stipulates that "it is the responsibility of the hospital and its personnel to safeguard the clinical records of the patients and to see that such records are available only to properly authorized individuals or bodies."

Information in medical records falls into two categories, non-privileged and privileged. Non-privileged information is unrelated to the treatment of the patient. No authorization from a patient is needed to disclose the following ordinary facts: (1) dates of treatment, (2) dates of admission and discharge, (3) number of times and dates on which the physician attended a patient, (4) fact that the patient was ill and operated on, (5) the complete name of a patient, (6) address at time of admission, and (7) name of relative or friend given on admission. However, discretion should be used and care taken to make certain that the inquiry is a proper one.

Privileged information is related to the treatment and progress of the patient and can be given out only upon written consent of the patient or guardian. Only abstracts of privileged information should be given to the attending physicians for their own use without this permission. The physician does have the right to maintain personal records of his hospitalized patients and these he should keep in his own office.

In releasing any medical information, non-privileged or privileged, care must be exercised to protect the best interests of the patient. Careful attention must be given to the formulation of policies governing the release of information, preparation of consent forms and the release of information to third party payment cases, research personnel and government agencies.

Medical records to serve in defense of a claim must be accurate, objective and complete. Emphasis should be given to the legal implications of every entry made in a medical record since it is essential that they be accurate and complete. Any omissions or mistakes from the intake procedures through to discharge may undermine confidence in the record as a whole. Doubt could be created as to whether or not all information has been reported, or whether or not it is accurate.

DEPARTMENTAL RECORD KEEPING

In discussing this subject it is important that we have a clear understanding of the definitions of a record and a report. *A record,* is something set down in writing or otherwise recorded for the purpose of preserving memory, or authentic evidence of facts and events. A *report* is a formal statement of the result of an investigation or an account of occurrences for the purpose of circulating related facts.

Recording

Recording in medical records covers four major areas:

Identification information. This information consists of the patient's name, address, age, family status, educational background and work experience, and this is most frequently obtained by the admitting officer of the hospital. If routine in-

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formation so obtained in your hospital does not provide all the background needed, additional information should be obtained on the patient's first visit. This can be done through formal interview or informal conversation.

Condition on admission. A description of the physical and/or mental aspects of the patient's condition at the time treatment is started in your department. This description will serve as the basis from which changes in the condition can be measured as the treatment progresses.

Progress notes. The record of observations of the patient's response to treatment. This is the most important item of recording in the medical area and will be discussed in greater detail later.

Supplementary information. The recording of observations of the patient not related to treatment. These facts should not appear in the progress notes of an unrelated discipline, but should be recorded separately and forwarded to the other disciplines concerned.

Reporting

Reporting is a composite of the records and basically covers four major areas.

Initial evaluation of condition. A summary of the patient's condition on admission, plus his evident potentials to accept and adjust to treatment.

Treatment plan. A summary of the treatment program as initiated and summaries of changes instituted as it progresses.

Progress during treatment. Summaries of the progress notes.

Final evaluation of treatment. Summary of the whole treatment program and results.

Up to now we have considered recording and reporting very generally, and several specific reasons for keeping good records become evident. These reasons are to comply with the law and substantiate a claim; communicate with the attending physician and other disciplines working with the patient on progress made; interpret the treatment program to the patient, his family and to the public and professional groups; facilitate efficient operation of a department when the staff changes due to illness, vacations or new personnel; aid in-service and student training programs; evaluate the effectiveness of your department's program; and aid special studies and research.

WHEN TO WRITE

One of the most frequently asked questions is "How often should notes be written?" Because recording is a means of preserving memory, observations should be recorded at the time of occurrence. This should be interpreted to mean within a 24-hour period following the occurrence, not a week later or a month later. Our memory has a way of playing tricks on us and the record of an occurrence will decrease in effectiveness if we wait too long.

Reporting should not be done entirely on a regular schedule of once a month, or once a week. It will be much more effective if it is timed with the results obtained in treatment of the patient, the physician's examination of the patient, and the needs of other disciplines interested in the patient. All results obtained will not be of a positive nature; regressions, failures, plateaus reached are as important to report as progress.

HOW TO WRITE

The specific art of writing good progress notes (recording) and reports needs to be developed and improved constantly in the field of occupational therapy. First and foremost we must learn to observe. To observe is to skillfully see or hear. We must become trained in what to look for or listen to. Then we must learn to relate our observations. This can be done orally or through the written word. In describing observations in writing, three necessary qualities should be developed by the professional person: (1) *accuracy,* the ability to express what has been seen exactly, precisely and correctly; (2) *honesty,* the ability to be fair, true and just in putting one's observations into words; (3) *thoroughness,* the ability to give careful attention throughout the writing and not be superficial. If these basic qualities are developed, meaningful records and reports will result.

Progress notes (recording) and reports are composed of three essential parts:

Aim of treatment. Physicians give us our medical direction by checking statements on prescription blanks or writing directions which remain in the permanent record. These include such statements as "increase muscle strength," "develop physical tolerance," "train in daily skills," "stimulate," "maintain morale," "alleviate guilt," "develop interest in group activities." These aims should be spelled out in detail by the professional in his own departmental records. These aims should be defined in relation to each individual patient's needs.

The treatment. A description of how the aim is being accomplished through procedures, positioning, adaptations, types groups, use of colors, methods of socialization and so on.

The patient's response. His progress, regression, attitude, cooperation and so on.

Analyze the records you are keeping today with respect to these three points and see how complete they are.

In the writing of records and reports, the command of language is important. It is not easy to put your thoughts on paper for another to read. Too often misinterpretation is the result. Through practice one can learn to describe aims, treatment procedures and observations so they

will not be misunderstood, and will tell the treatment story in logical sequence. There are a few rules we should remember in our writing:

(1) Learn first to identify and then exclude vernacular or "jargon" words and phrases. They are meaningless to others reading the record.

(2) All writing should be done in the third person.

(3) Eliminate empty phrases such as "so that," "in case of," and develop terseness in writing. Terseness is nothing more than being elegantly concise, short and to the point.

(4) Do not try to appear learned by making an effort to "load" reports with scientific words. They have their place in reports and records, but many times everyday language will describe our thoughts better and be more accurately understood by those for whom we are writing.

There is a great need for all of us to establish and develop "yardsticks" or scales of measurement that can be used to rate our patients' progress. Until we can define such terms as "good, moderate, fair, poor" into logical steps with meaningful interpretations, we are doing no more than risking a guess at the results we are recording about our patients. The more scientific we can be in our means of measurement the more significant it becomes.

Another method of recording and reporting which should be developed is the use of charts and graphic records. They are easily read and can simplify our recording process. It is one thing to propound general principles of record keeping. It is another thing to put this theory into practice.

SUMMARY

The art of record keeping has four basic points: (1) knowing the difference between a record and a report; (2) understanding the administrative and medical records to be kept in the institution in which you are employed; (3) understanding how these records integrate; and (4) knowing how to put what you see, or the facts you have, into words that will give an accurate account.

There is no limit to the refinement that can take place in recording and reporting. The development of good administrative and medical records is a continual process of systematic re-evaluation. It is a responsibility we must assume in our jobs. When it is well done, we will command respect from all with whom we work.

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GREETINGS TO CONVENTION OF OCCUPATIONAL THERAPISTS

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As a representative of the American Psychiatric Association, the oldest society in the country concerned with mental health, it is a distinct privilege to extend greetings to you, who belong to one of the newer and most promising professions in this area. I also bring the good wishes of our president, Dr. William Malamud, who I am sure shares my high opinion of the contributions which occupational therapy makes daily to the field of medicine.

The concept of the therapy of organ systems has increasingly yielded to the broader approach of the therapy of the whole person, and the circle of personnel offering treatment to the patient has correspondingly widened. Most properly, today we think in terms of several major kinds of therapy. The care of all patients centers around (1) the definitive therapies, including medical, surgical, and auxiliary procedures, and (2) restorative and reconstructive therapies like occupational and physical therapy.

Perhaps there is indeed nothing new under the sun, and accordingly the concept of occupational therapy is not new. The realization that activity provides an outlet for emotional pressure, and that disturbed patients can sometimes be distracted from their concerns by a new and interesting stimulus has dictated much psychiatric prescription in the past. It is, however, the formulation of basic principles of occupational therapy, the collection of knowledge about the specific cause-and-effect of activities, and the teaching of ways to apply this knowledge which is relatively new in the field of mental health. The growth and development of occupational therapy as a profession, with specified standards of training and organizational control, is an

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advancement, then, for the field of medicine in general.

As occupational therapy has grown beyond the role of "giving the patient something to do," it has become an increasingly potent force in the treatment of the mentally ill. I have long observed and attempted to capitalize upon the natural drive of the patient for activity, and for stimulation of interest. Relief of tension and anxiety, contrary to the frequent belief of the patient himself, comes less from rest or from trying to gain relief, than from becoming absorbed in some other activity. Change, not rest, is the major requirement. Like happiness, relaxation and restoration of resources cannot be pursued; these things become a part of life when life has purpose and meaning, when one has stopped trying to hunt them down. When we teach this to patients through their own experience, we do much more than help them relieve a temporary stress reaction, or a group of symptoms. We teach them principles of mental health which should have an ongoing influence in their lives. We teach them specifically what to do with negative energies, and even how to convert them into positive vitality.

Only a small portion of such education can be accomplished through psychiatric prescription alone. Few patients can retain psychiatric guidance throughout their lives, nor should they. In any case, the transfer of new emotional skills of life (in other words, the process of working through) is necessarily a matter of practice on the part of the patient. Occupational therapy is one of the bridges leading from the island of the psychiatric hospital back to everyday life. It implements "reversibility" of mental illness. In fact, rightly used, it may prevent complete isolation of the patient even in the severe stages of his illness.

The definition of the term therapy is ever broadening in its application to clinical practice. The importance not only of selected activity for the patient, but also of the nature of his relationship with his teacher, friend, and group leader (the occupational therapist) is becoming more recognized. From the beginning of hospitalization, occupational therapy is an enriching, broadening experience for the patient. It complements other treatment designed to remove the destructive influence of other areas of his experience. Furthermore we note increasingly the broad avenue to relationship with the patient which is afforded by occupational programs; this is often the first setting in which the patient becomes accessible, or communicative. The role of the occupational therapist is, therefore, a crucial one, part of the core of treatment, and deserving of the highest quality of personnel, training, and facilities.

BEHAVIOR, OCCUPATION AND TREATMENT OF CHILDREN

JULIUS B. RICHMOND, M.D.*

In the title "behavior, occupation and treatment" are words that were not chosen lightly. "Behavior" is included because one must have some knowledge of the dynamics of emerging behavior in order to understand a child and his family. We need to know the rate at which behavioral patterns emerge and the appropriateness of the behavior. We will elaborate on this later. "Occupation" in a broad sense provides stimulation for the infant or child. Lest anyone have a parochial point of view concerning occupation, I should like to point out that Aldrich, a number of years ago, stated, "Child's work is play." Thus when concerned with children, one must accept the fact that play is the vehicle for communication and ultimate growth. The use of the word "treatment" requires little justification since we are in a helping situation. This designation emphasizes our overall objective of helping children attain their greatest potentialities.

Since the occupational therapist comes into contact with families during periods of stress and adversity, an understanding of basic adaptive processes is important. Utilization of professional skills can be rendered most effective when undertaken with insight and understanding of the problems which the family is facing. Without such understanding, services may be rejected or utilized ineffectively.

It is significant not only to know something of the stress which is being experienced but also the timing of the stress may be of central importance. We have tended to neglect the matter of timing altogether too frequently. The timing of an adverse experience — whether encountered during the period of infancy, preschool,

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school or adolescent years — will have much to do with the degree of its impact on the total organism. The intensity of the stimulus must also be considered as a factor in this equation. In order to illustrate the importance of interaction of stress, its intensity and the age period at which it occurs, I will consider in some detail the impact of the process of separation of a child from a parent.

The impact of separating experiences are frequently observed by the occupational therapist, especially in the hospital setting. Indeed, hospitalization inevitably involves some degree of separation. Separating experiences have been a matter for considerable interest in recent years, probably highlighted by John Bowlby's monograph on "Maternal Care and Mental Health."

Occasionally we encounter the impact of separating experiences prior to the child's having come to the hospital. I would like to illustrate this with a patient we have had an opportunity to study over a period of years. This child was first observed by us when 14 months of age because of failure to thrive. Her weight was 10 pounds and she had a marasmic appearance. Detailed studies for various metabolic disorders and congenital anomalies proved unrewarding. What was striking was the anxious, lonely appearance and searching movements of the eyes. We suspected that this child had experienced maternal deprivation. The history corroborated this impression when we learned that the mother, of limited mental ability, had largely withdrawn from intimate contact with the child because she thought she might "spoil" her if she picked her up. Some three months later this child had gained 14 pounds and appeared to be very content. This change was brought about by having the nurse and occupational therapist spend considerable time in stimulating activities with her. At the present time she is enrolled in school and is progressing reasonably well. Although she shows some distractibility in her work, she is managing to remain in a group setting in the school.

This child illustrates that we have come full circle: years ago infants admitted to hospitals had a tendency to develop this syndrome of anaclitic depression in the hospital because of insufficient stimulation. Now our hospital care is sufficiently stimulating to justify hospital admission for the treatment of the condition.

This clinical example of the effects of extreme deprivation is presented because the extreme often dramatizes the more subtle effects. Consider another example, an infant we observed had reacted to deprivation by causing himself to regurgitate food and to re-swallow some of it, just as does the ruminating animal; hence the designation of rumination for the syndrome. This baby was being reared by a mother who, for psychological reasons, had considerable difficulty in caring for him comfortably or intimately.

Again in the hospital this baby, as he experienced stimulation from the nursing and occupational therapy staffs, ceased to ruminate. During this period he changed from a depressed, sad-appearing boy to an animated, happy one. We managed during this time to work with his mother in order to help her develop a capacity to relate more intimately to her baby.

These clinical cases indicate the basic need of infants and young children for a continuing and stimulating relationship. Although we have demonstrated the effects of hospitalization as a corrective experience in these instances, we must remain aware of the possibility that hospitalization of infants and young children may be associated with some degree of separation and sensory deprivation. The studies of the impact of sensory deprivation on the adult reveal that even the mature organism requires considerable stimulation for adequate functioning and survival. The effects of deprivation in infants and young children have even greater meaning in the light of such studies.

The implications of such studies for our programs is clear. If we have under our care infants and young children, several preventive measures may be undertaken:

(1) Provisions for parents to remain in contact with the infant. The facilities for such provisions vary with the institutions, but it is always possible to retain parents within the program in some fashion unless geographic distance poses an impossible barrier.

(2) The provision of stimulating care for the infant. Here the professional skills of the occupational therapist and the nurse are significant. Stimulation comes through the physical care which the baby is receiving. Thus around feeding, diapering and preparation for sleep much of the stimulation occurs. As a consequence, the occupational therapist must be prepared to enter into nursing to some extent in working with infants while also adapting play techniques.

(3) Continuing contact with the same personnel. Minimizing the rotation of staff people involved in the care of the infant can help to reduce anxiety. Thus administrative decisions concerning schedules should be based on the needs of the child rather than on the convenience of administration.

Concerning prolonged care of infants and young children in groups, the effects of institutional care are not always so dramatic as the anaclitic depression previously mentioned. In well-conducted institutional programs today infants may appear to survive reasonably well. We are concerned, however, about the development of higher intellectual functions. The fantasy life and creative capacities

of such children often seem to be affected. This speaks for the need to provide stimulating play opportunities in the very early formative years. If occupational therapists have the opportunity to work with young children who for some reason must be in an institutional setting, their efforts will have implications going far beyond the immediate care of the child. Later personality development and intellectual function may be profoundly influenced.

I emphasize this early period because there is often an inclination to disregard it since the children may be non-verbal and are not in a position to acquire highly specific skills. But play — and varied play — is the building block out of which the occupational therapist and the other child care staff may stimulate healthy growth. We need an expansion of our programs for this age group in more imaginative ways.

Just as certain age periods are associated with certain vulnerabilities, we should recognize certain times during the child's hospital experience as also creating greater vulnerability. It becomes important to center our programs about these periods for all age groups.

(1) *The period of admission.* There has been considerable attention directed in recent years to preparation of the child for hospitalization. More significant, however, are the experiences after he arrives at the hospital. For the young child, breaking the continuity with the home routine can be minimized. Knowledge of eating habits, toileting and sleep are helpful as is the opportunity to bring a familiar favored toy or object. It is during this period, however, that contact with people assumes considerable significance. The occupational therapist is in a position to make this contact pleasant and stimulating. I have often said that if staff were limited, I would concentrate the time disproportionately in favor of the newly admitted children. If the initial orientation is good, relatively less time may be required later.

(2) *The evening hours.* Perhaps no period is as neglected in hospital routine as the hours prior to bedtime. I had this made obvious to me when my office was located across the corridor from the ward units and I had a continuing view of what transpired. Because professional staff—as do other human beings—prefer to be home evenings, the staffing is generally quite light. Yet this is the time children are accustomed to the intimate and stimulating associations of family life. Along with this, there is the specific anxiety associated with night fall and the general uncertainty we associate with darkness. This is the time at which contact with adults is reassuring. Small wonder that this is a period for reading, story telling and quiet games in the home. All of these have the effect of reducing anxiety and helping to master the separation associated with going to sleep. The peek-a-boo games of the young child assume greater meaning when we think of them in the context of mastering separation. Again I would emphasize that we need to be more energetic and imaginative in developing programs which will provide more adequate experiences during these hours.

Thus far we have discussed some of the hazards of the hospital experience and our methods for dealing with them. It is important to note some of the potential advantages of hospitalization for the child and the family.

Families or individuals cannot be spared adversity totally. Since all individuals at some time or other require medical care, it is well to offer an opportunity for the family to realize some gains out of their contact with the professional staff. The school age child coming to the hospital has an opportunity for a considerable learning experience — regardless of the nature of the illness. The opportunity to learn that people outside the immediate family circle are interested in him and that they have some understanding of him is broadening as well as comforting.

Since medical care is associated with some concern about his body, the child may, through play, reveal considerable information concerning his fantasies about his body or what may be done to him. These observations may reveal distortions which lend themselves to correction, or they may reveal disturbance which needs to be called to the attention of the medical staff.

Play is the medium of communication for children and we must be tuned in to appreciate its significance. Through play may come the mastery of the child's anxiety. He may repetitively be able to deal with his anxiety concerning injections or the surgery which may be in the offing. Everyone develops concepts about his own body. These concepts may be distortions. Through play experiences the staff may be in a position to learn of the distortion and why. If we are not observant, however, this opportunity is lost to us. We hear only what we are tuned in for. The breadth and depth of our receiving apparatus is increased by the training process.

For the adolescent we need to respect both the need for some privacy and for some group identity. Although some centers are fortunate enough to have an adolescent unit, most will not find it possible to establish such programs. The main source of difficulty in institutional programs for adolescents is that the adolescent doesn't want to be treated as a child. If we respect them and do not depreciate their often amateurish efforts to appear grown up, we can deal relatively effectively with them. Just as we need to respect the needs

of the infant in program planning, so do we need to respect the needs of adolescents.

We have said relatively little about the care of children with specific diseases in this discussion. This is not fortuitous, for if one can have objectives constantly in mind, the techniques and programs flow logically. I should mention, however, that we need to know much more about the psychology of children with various diseases. More research is needed into the adaptive processes of children with chronic disorders such as diabetes, nephrosis, rheumatic fever, muscular dystrophy and others. We have long had an interest in children with inevitably fatal malignant diseases such as leukemia. It taxes us all to deal constructively with a child experiencing multiple physical problems and declining energy, and with the emotional stress in the family in the face of inevitable disaster. As we learn more we will become more skillful. Research endeavors enable us to guess less and know more.

For all of us dealing with children, some philosophy of child rearing is basic. At the outset I indicated that we are all striving to help each child attain his greatest potentialities. Lest we think that we have only recently become enlightened in these matters, I would call your attention to the following rather ancient quotation:

"Infants who have just been weaned should be permitted to live at their ease and enjoy themselves; they should be habituated to repose of the mind and exercise in which little deceptions and gaiety play a part; their diet should be light in quality and moderate in quantity; for those who, at the period of weaning, stuff them with food and endeavor to give them rich, nourishing foods will pervert their nutrition and prevent their growth from the very weakness of their natures. Some of these children will be affected with ulcerations and inflammations of the intestines, with procidentia ani and with grave disease, resulting from the frequency of indigestion and diarrhea. After the sixth or seventh year, little girls and boys should be confided to humane and gentle teachers: for those who attract children to themselves, who employ persuasion and exhortation as a means of instruction and who praise their pupils often, will succeed better with them and will do more to incite their zeal to studies; their instruction will rejoice the children and put them at their ease. Now, relaxation and a joyous spirit contribute much to digestion and favorable nutrition; but those who, on the other hand, are insistent in instruction, who resort to sharp reprimands, will make the children servile and timorous and will inspire them with an aversion for the objects of their instruction: it is by beating them that they expect them to learn and recollect things, even at the very moment when they are beaten, when they have lost their courage and presence of mind It is not necessary either to torment children just beginning to learn by trying to teach them something through the whole length of the day; on the contrary, the greater part of the day should be devoted to their games. In fact, even among the most robust people, who have already reached the age of complete development, deterioration of body is noticeable in those who have applied themselves too arduously and without interruption to the pursuit of learning. Children of twelve years should already frequent the grammarians and geometers and exercise their bodies; but it is necessary that they should have preceptors and supervisors who are reasonable and not entirely devoid of experience, so that they may know the amount and proper time for meals, exercise, bathing, sleeping and other details of personal hygiene. Most people will pay a high price for grooms for their horses, choosing for this purpose careful and experienced men, while they will select as teachers for their children individuals without experience, who have already become useless and incapable of rendering any of the ordinary services of life."

This was written by a Greek physician, Oribasius, in about 325 A.D.

The November, 1959, issue of the *Hospital and Institution Book Guide* contains a list of books of interest to occupational therapy and recreational therapy departments. The October, 1959, HIBG suggests recent books for older readers. The lists are selective, most titles are annotated, and the books cover the past two years. Lists on a variety of subjects of interest to hospitals and institutions have been published and others will come out in the future.

Conference Vignettes

Photographs by Opal Cutler, O.T.R.

ATTITUDES TOWARD REHABILITATION OF THE DISABLED*

WILLIAM GELLMAN, Ph.D*

The emergence of rehabilitation as a social movement may be a significant contribution of the twentieth century to human development. Each step toward freeing human potentiality from the limitations of disability contributes to the dignity and growth of all mankind.

Achievement of the rehabilitation goal—helping the disabled person to attain his maximum level of adequacy in work, love, play and social relations—calls for public and private attitudes which permit a disabled person to participate in society. Community and individual acceptance of disabled persons is as important in successful rehabilitation as success in overcoming, biological, physiological, psychological or mental handicaps,

Community and individual attitudes toward rehabilitation and the disabled are critical in four areas: (1) the meaning of disability; (2) the social role of a disabled person; (3) the treatment approach; and (4) community acceptance.

THE MEANING OF DISABILITY

Public attitudes toward the disabled reflect private emotions. The meaning of disability is embodied in personal answers to questions such as: Do I fear disability? Can I accept mental or physical impairment? How do I react to diminished mental or physical vigor? Am I ready for the difficulties of increased age? Do I dread the appearance of deformity? Can I adjust to decreased adequacy? Do I fear the mentally or physically disabled?

Fear of being handicapped influences our attitudes. We dread the effects of disability and reject it in others. Language and thought confirm our prejudices. The words "handicapped" and "disabled" lead us to equate *disabled* with *not able* and to speak of the handicapped as being *unfit* or unable to maintain themselves in normal society.

Our appraisal of ourselves and others takes into account the presence and extent of disability. We are critical of inadequate performance by others and of persons with an unusual or defective physical appearance. We devaluate ourselves if our appearance does not conform to accepted social norms. We dread failure or inability to live up to the expectations of others.

Our attitudes toward the disabled are ambivalent. Increasing stress is placed upon youth, wholeness and bodily perfection, which the communications industry uses as advertising tools. A continuous barrage advertising health and well-being inculcates the belief that disability or injury result from inadequacy, misfortune or lack of care. Whether expressed consciously or not, the assumption is made that a handicap is a bar to productive living. Yet, at the same time, we pity the handicapped and express our desire to help them through public and voluntary health agencies supported by tax funds and contributions.

SOCIAL ROLE OF THE DISABLED PERSON

Devaluation of the disabled as a person is evident in social, educational and vocational discrimination. Social attitudes toward the disabled, as reflected in child-rearing practices, emphasize the barrier between the disabled and the so-called normal. The disabled person is enmeshed in a network of help which encourages dependence and self-depreciation. He is taught to assume the role of a "handicapped person" and acquires behavioral and attitudinal characteristics which separate him from the majority culture.

The social role of a handicapped person is characterized by relatively low status. We presume that the disabled person is relatively nonproductive as compared with most persons. Psychologically, this social role carries in its train a feeling that limitations imposed by a disability are absolute losses which restrict social participation. The disabled person is on the alert for slights. At the same time, he expects and becomes dependent upon preferential treatment. He develops feelings and attitudes which parallel the social aspects of his role as a disabled person. Among these are: a sense of misfortune; a feeling of isolation and loneliness; attitudes of dependency; the expectation of being a bystander; and internalization of psychological and physical energy.

Society prepares the disabled person to accept a negative social role and, in doing so, to expect to occupy one of three lower status levels—a pariah, an economic liability or a person with limited usefulness.

If differences in appearance, gait, mannerisms or speech are marked, the disabled person is considered a pariah and confined to institutions, segregated workshops or special schools. If he seeks companionship, his circle of acquaintance is limited to other disabled persons. In such segregated groups, he finds a sense of belonging.

A disabled person will be considered an eco-

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nomic liability if the family cannot assume the economic or psychological burdens of disability. The disabled person is viewed as a threat to family survival. His fate becomes less important than that of the family. When psychological or economic resources are insufficient, removal from the family to an institution serves as a safety valve.

Limited usefulness, the third status offered the disabled person, permits him to make a contribution within clearly defined limits. He may be trained for a lower-caste service operation, he may be placed in segregated positions or he may find refuge in sheltered workshops. This attitude is exemplified in the custom of providing newspaper and candy stands for the blind or reserving jobs as watchmen or elevator operators for accident victims.

The status of the disabled reveals the contradictions in our attitudes. We help disabled persons overcome physical, emotional and mental disabilities. However, we leave them with social handicaps which reduce the effectiveness of rehabilitation.

TREATMENT APPROACHES

The ideal professional person in rehabilitation assumes that the dichotomy in attitudes exhibited by society toward the handicapped does not exist in the rehabilitation process. He believes that when he accepts a handicapped person as a patient he accepts him as a person. He takes it for granted that rehabilitation is free of the forces of discrimination. Is this contrasting picture of a discriminating society and an unprejudiced rehabilitation therapist a reasonable facsimile of actuality?

In practice, professional rehabilitation personnel display semi-prejudicial attitudes which correspond to the status consciously or unconsciously accorded disabled persons. The professional worker who feels that the disabled person is a pariah adopts the attitude of an omnipotent healer. If he considers the disabled person a liability, his approach is a charitable one. If he believes there is a realm of usefulness for disabled persons, he adopts a therapeutic approach.

A professional person who sees himself as an omnipotent healer feels a deep conviction of superiority. His treatment approach is characterized by unwillingness to have the patient participate as an individual in the healing process. He regards disabled persons as malleable individuals who are to be shaped, molded or educated into health. He accentuates the distinction between the therapist and the patient in all phases of the rehabilitation process. This attitude has the effect of removing the patient from rehabilitation. Treatment becomes more important than the patient.

A second semi-prejudicial attitude, the charitable one, views disabled persons as economic, psychological or social liabilities. Professional persons who feel themselves philanthropists regard the disabled as passive recipients of charity who exist to permit the better educated or more fortunate members of society to display their helpfulness. The relationship between the charitable professional and the disabled person is reciprocal. The donor needs a recipient.

Rehabilitation therapists who base their professional activities on charity tend to devote their efforts to good, middle-class patients, who are grateful and motivated towards successful rehabilitation. They tend to reject in subtle ways ungrateful patients who come from lower socioeconomic groups with goals and values which differ from those of the therapists. Since most professional rehabilitation personnel come from middle-class backgrounds, they feel most comfortable with persons of the same class and find themselves uncomfortable with other types of persons.

The therapeutic approach, which is becoming more prevalent, begins with the belief that disabled persons are as valuable as non-disabled persons and that disabled persons can participate in society. It accepts differences and diversities among patients. It takes for granted the ability of disabled persons to develop their lives in accordance with their values and to participate actively as members of society.

The therapeutic approach assumes the importance of cultural differences and examines values which therapists take for granted. It assumes individual differences in what disabled persons consider useful and worth striving for. The bland statement that the patient is "unmotivated" may mean only that he is not motivated toward the goals considered valid by the therapist.

The professional person must be willing to experience failure by attempting to work with people whose attitudes do not insure success. There are different types of failures just as there are different types of success, and it is only through careful examination of our failures that we are able to broaden our approach to people. One of the greatest opportunities of the professional person is that of learning from our patients that there are as many ways of helping as there are people.

Our analysis indicates that professional approaches based upon charity or omnipotence are actually semi-prejudicial. They tend to see the patient as either a passive acceptor or as a person apart. The therapeutic approach towards which rehabilitation is moving and should move uses the patient as an active rehabilitation instrument, who, by participating in the rehabilitation process, prepares himself for participation in society.

THE COMMUNITY AND THE DISABLED

The objective of rehabilitation is the return of the disabled person to society. He accomplishes this by becoming a member of the community, and it is in the community that the value of rehabilitation is tested by its acceptance of the disabled.

In the community we display attitudes as members of groups—neighborhood groups, work groups, recreational groups or citizens groups. If our attitudes toward the disabled are positive, the community will offer them assistance in developing personal and social competencies. It will encourage the disabled to participate in all life areas.

Organized and expressed community attitudes are favorable toward rehabilitation. Interest and support are at a peak. Legislation provides funds for increasing the number of rehabilitation facilities, for training rehabilitation personnel and expanding the scope of special schools and institutions for the handicapped.

Public and private agencies foster and develop programs for helping disabled persons become adequate in their work, family and social lives. Volunteers and professional personnel are ready to help the disabled person learn necessary skills and secure work or find planned social activity.

There is a gap between our organized efforts and the attitudes we display as individuals. Despite the encouragement and assistance of rehabilitation agencies, the disabled person finds it difficult to secure companionship or work. He is not accepted by the community as a productive person or a socially valuable member. He encounters resistance in the area which matters most—acceptance as a human being who belongs in the common stream of humanity.

WHAT CAN BE DONE?

The cleavage in attitudes corresponds to contradictions in ourselves. While we as a society and as individuals promote rehabilitation, we are prejudiced toward disabled persons who are the products of rehabilitation. We reject them subtly or overtly and consider society's obligation discharged when we practice toleration.

The difference between individual and social attitudes reflects our desire to maintain psychological distance between disabled and non-handicapped persons. We manifest negative attitudes in face-to-face contacts and positive attitudes when we deal with the disabled as a group.

Fear of disability in ourselves and the presumption that the disabled person differs from the so-called normal underlie our need to separate ourselves from the disabled. If our analysis is correct, we can undertake to remove prejudice by accepting disability as a natural event and by destroying the concept of a single social role for all disabled persons.

Our program to change the social climate of prejudice would be twofold: (1) a continuing educational program which stresses the ability of the disabled to function as school, work and recreational companions of the non-handicapped; and (2) an action program which fosters participation in the give-and-take of ordinary life and permits normal relationships between the disabled and non-disabled.

To overcome personal prejudice we must prepare ourselves for the inevitability of change and the hazards of human existence—accident, injury, illness or aging. We must acknowledge our fear of disability and recognize its naturalness. As we learn to accept disability in ourselves, we can accept it in others.

C. P. COURSE

A postgraduate course which will study the disorders labeled "cerebral palsy" will be presented September 6 to 23, 1960, at the Institute for the Crippled and Disabled, New York City, and sponsored by the International Society for Welfare of Cripples and United Cerebral Palsy, Inc.

About thirty lecturers will contribute to this bio-social approach. The course is limited to twenty persons and tuition is $100. For further information write:

Dr. Isabel P. Robinault
Institute for the Crippled & Disabled
400 First Avenue
New York 10, N. Y.

TREATMENT OF THE ADOLESCENT: SOME PSYCHOLOGICAL ASPECTS

IRENE JOSSELYN, M.D.*

As we are progressively learning more details of the growth psychologically of an individual from infancy to adulthood we become increasingly aware of the complexity of human psychology but also less confused about most of the normal behavior of any particular age group There is one exception to this, however. The more we learn about adolescence the more disorganized the picture seems to become. Perhaps the most important concept that has evolved from the many studies of the adolescent is that confuson is inevitable. The adolescent himself is disorganized.

An essential part of the psychological growth process from infancy to adulthood is adolescence; out of the chaotic state of that age group evolves the adult personality. While the components of adult personality unquestionably develop for the most part in the first six years of life, subject to some modification during the immediately following years, it is during adolescence that ultimately is determined in what fashion those components will be expressed in the adult personality. Adolence is the growth period in which all the earlier components are shaken up together to finally come to rest again in some type of cohesive pattern.

During this period of jumbled parts the individual requires a great deal from the people in his environment. He needs understanding and the privilege of not allowing himself to be understood. He needs emotional support and respect for his self-sufficiency. He needs freedom, and limits imposed upon him. He needs contact with others, and privacy. Above all, he needs an opportunity to be an adolescent sufficiently long to shuffle the parts frequently and try several partial configurations, and equally the assurance that he is expected to become an adult.

In spite of the confused picture both in his behavior and in his needs certain typical responses can be identified. If the significance of those responses is recognized there are certain functions the adult can perform in his relationship with an individual adolescent that can be both meaningful and helpful to the latter. Understanding of adolescents may also relieve some of the anxiety and decrease some of the frustration and irritation adults experience in working or living with individuals of this age group.

There is one general, very valuable role that an adult can assume. He can be an adult. This statement, put so baldly, may appear self-evident. In reality adults often fail the adolescent by not being adult or at least pretending they are not. There is a superficial rationale for that behavior. An adolescent often complains that he is not understood by his parents, teachers and other mature individuals involved in his daily living. His complaint, within limits, is justified; he presents such a confusing picture. Certain people, responding to this plea, attempt to show they do understand by expressing agreement with the adolescent's confusion. They are like the psychiatrist who, when confronted with a suicidally depressed patient, indicated to him that he could cure him of his depression—but why should he? It is a depressing world situation. If a depressed patient wants to talk to someone also suffering from a depression, he can easily find such a person. If he wants help he expects to find it in a therapist, a person who has found some constructive way to deal with the discouraging aspects of the world situation and is therefore free to help with the deeper causes of the individual's depressive symptoms. Equally so, if the adolescent wishes to talk to other confused people he can talk to his peers. When he talks to an adult he is seeking help in some form or other.

The poignancy of the adolescent's complaint that no one understands him is due in part to the fact that he cannot understand himself. His complaint is a plea, not only that he be understood but also that he be helped to understand himself. He wishes to have someone understand his confusion but to utilize that understanding in order to make organization out of that confusion. To give an over-simplified example, when an adolescent boy says he hates girls because they are predatory, demanding, self-centered and don't understand how one feels, he does not really wish the adult to share this condemnation of a difficult but essential, opposite sex. He wants to feel that the adult knows what the younger person is talking about so he does not answer with the assurance that all females are made in heaven and retain that aura. But he also wants to learn if in the experience of an older person there are positive values to the opposite sex. He hopes the adult will indicate that some girls are very difficult, all girls present some difficulties but many girls also have another side to their per-

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sonalities. Indirectly in the latter instance the adult is acknowledging the core of the adolescent's difficulty. It is not that no girl is any good but that the boy is afraid of the things that are not good about them and of his own conflicts. He is afraid of them and yet feels drawn to them. The adult's function is to assure him he need not be so paralyzed by his fear.

The adolescent profits most from the help an adult who respects the adolescent can give. The adolescent, in spite of his phases of cockiness and arrogance usually has no real confidence in himself. His defense is sometimes difficult to recognize as a defense because he expresses himself so positively. An adolescent, most of the time, feels as if he were a mixture of unrelated hands and feet, both physically and psychologically. His fantasy of what he wishes he were and his fantasy of what he is are both rather typically unrelated to the facts. Underneath any disguising shell he has built around himself he feels inadequate, ugly and/or unworthy of respect. For ultimate psychological health, once this internal churning subsides, he must attain a feeling of respect for himself. One of the sources of this ultimate resolution will be an external one, the attitude of others towards him and especially the attitude of older people. Thus an adolescent should be able to turn to adults anticipating they will, warmly, without anxiety and without subtle ridicule through a caricatured pretense of respecting him, take him seriously. He should be able to anticipate that the adult will laugh with him but *never* at him even if he laughs sarcastically at himself.

There are several areas in which this respect for the adolescent can fail to materialize unless the problems behind the adolescent's behavior or verbalization are recognized. One of the most difficult areas in which to maintain this confidence-giving respect of the adolescent while meeting his needs is when his behavior reveals his vacillation between dependence and independence. The adolescent's struggle for independence, coupled with his limited experiences, lead him sometimes into ridiculous and even dangerous situations. He needs the guidance of a more mature, more psychologically organized individual in this struggle. His very goal of independence causes him to resist such guidance except when it is given in a form that allows him to still feel independent. An adult who understands but also respects the young person will be most skilled in providing acceptable guidance. Ridicule or contempt will either stimulate excessive independence or a greater feeling of inadequacy—a feeling of being inadequate far beyond his actual limitations.

In spite of the most skilled guidance however, at times any adolescent will surge toward an independent status for himself that is either in reality beyond his capacity or, more commonly, he feels is beyond his capacity. He becomes frightened. Sometimes he quietly retraces his steps to safer ground and his modification of his goal is not apparent. Often, however, his anxiety results in his abandonment of his goal for independence. He reverts to a dependent pattern of behavior resembling a very young, helpless child. Then there is the temptation to tell him to "act his age." The fallacy of such a remark is that he is acting his age. He is acting like an adolescent who is frightened. The function of the adult is to let him be dependent until the adolescent has mobilized his internal strength sufficiently to again start on the path towards more independence.

The adult should not only respect the adolescent during the manifestation of these extreme swings between independence and dependence but also should be prepared to be accused of babying and also of not helping. This was succinctly illustrated in a knitting episode with a girl of fourteen. When the occupational therapist offered to help her with a rather intricate pattern the girl haughtily said that she knew how to follow directions. Having pretty completely messed up a few inches of knitting she angrily called the occupational therapist to her bedside, tearfully berating her for not standing by and helping her with something that was too hard. The occupational therapist started the knitting over, urging the girl to do the actual knitting while the therapist guided her. This the patient refused to do, begging the therapist to do "just a little more." Finally the girl, who it should be stated was usually very charming, grabbed the knitting saying "look what you've done. You've done it for me and I wanted this to be all mine," whereupon she ripped out the beautiful work the occupational therapist had done. In such an episode only respect for the adolescent and her problems can preserve one's professional equanimity and therefore professional value.

The adolescent is struggling to determine who he wants to be. As he carries on an internal struggle to sort out his parts and determine what can be made of those parts, he looks around him to find models to use as guides. It is important that he find adults that he can respect. Regardless of his sometimes overt disrespect for adults, he hopes he is wrong. He seeks, as a model, someone who has a pattern of behavior that is dictated by a well defined but reasonable conscience, and one that is serviceable in the social structure in which he lives. He does not feel comfortable with a person whose own conscience is so rigid it allows no tolerance for the standards of others that do not conform to his.

If the adult's conscience does not permit him to smoke, the adolescent wishes that adult to be comfortable in expressing his own reasons for not smoking but also to show tolerance for those who do. On the other hand he does not feel satisfied with an individual who can easily violate his own conscience or is completely tolerant of willful violations by others. If the adult indicates that stealing is wrong but obviously enjoys his own or other's successful thievery, the young person finds little constructive value in the adult. He can find the over-rigid or the ineffectual conscience among his peers. He is striving to grow beyond that level of development and wishes older people to be available models so he may experiment with being like them, to see how such a model suits him. He wants to understand how the adults feel about certain behavior; he also wants the adult to try to understand different behavior. But those adults he finds of most value to him in that exploration are those whose attitudes and behavior he respects. He often chooses a person with whom he has no direct contact, for instance the matinee idol, because he can *imagine* without threat of disillusionment that that person has all the characteristics he wants in his model.

An adult whom an adolescent respects has another important function. Adolescents need limits placed upon their behavior in those areas in which their behavior may be damaging to them or to others. In actuality most adolescents, even though for face saving reasons they must verbally protest against such limits, value them if they are justified. The adolescent in his uncertainty sees such limits as protection provided by the outer world when he feels unable to protect himself. He, however, is not always able to, even in secrecy, evaluate the validity of certain limits. Unsure, he will accept them when imposed or considered valid by someone he respects.

The adolescent finds it very difficult to tolerate ambivalent feelings toward anyone. Someone he likes he will see only as likeable because to see a negative aspect would necessitate disliking. When he does dislike he is apt also to do it totally and blind himself to positive aspects of the person. Because of this inability to tolerate opposing feelings for the same person, he is not consistent. If negative experiences with a person who is meaningful to him can be ignored he does so. If they happen to be related to particularly important considerations to him at the moment, he may effectively ignore his previous positive feelings. People who are really important to him, either because of their emotional significance, their authority, or their resources he frequently either hates or loves, pendulum-like, but with an unpredictable rhythm.

The adolescent struggles with his own sexual feelings. The beginning functioning of the reproductive glands has brought on not only important physical changes but equally important psychological changes. He is flooded with feelings that are basically sexual in nature but which find expression also in other forms. He characteristically is more emotionally labile because he is more reactive to stimuli. He may express this at times (and with rapid changeableness) in esthetic responses, in absorption in learning, absorption in sports or absorption in what others see as "doing nothing." Adults who share his interest become very meaningful to him. Their responsibility in this is a dual one; to enrich the young person's experiences in those areas of interest and to help him find additional avenues of expression. The adolescent is preparing himself for a multiphasic world. Ultimately through vocational and avocational selection he will find his own place where he will invest his energies. A breadth of experience will enable him to more wisely select the areas for ultimate depth of interest. It is often very gratifying to an adult to find an adolescent who intensely enjoys some pleasure the adult shares. This is especially true if the latter has felt lonesome in that enjoyment because other people have been too busy to fully share it. The adult then may be tempted to fence in the adolescent and himself in the framework of that interest and fight off any intrusion of other people or other stimuli. When so tempted that adult should spend more time in seeking out another adult who has already hemmed himself in by a single interest.

In addition to this broad effect of the psychological changes during adolescence, feelings that are more definably sexual are experienced. The aroused sexual feelings during the early phase of adolescence are not channeled into a final form of outlet. Any feeling of affection for another, if it reaches a certain intensity, will be sexually colored for the adolescent. An example of this is the familiar picture of the "crush" phenomenon. The young person may find another person who is emotionally very meaningful to him. There may be a variety of reasons for this emotional tie. The other person may be the source of dependent-like security. He may be an ideal that the adolescent strives to emulate. He may be a person of the opposite sex who represents all the young person longs for as a sexual complement to himself. He may be a friend with whom many interests are shared. Regardless of the significance the other person has, the relationship is rich and intense. This intensity results in the arousal of undisguised, or in more psychiatric terms, unsublimated sexual feelings. When an adolescent responds in this way to an adult, two

diametrically opposite but equally unfortunate responses may occur. The adult may find gratification in the sexual aspect of the adolescent's response and subtly encourage its further development. This either may arrest the growth process so that the sexual feelings are not able ultimately to be channeled to an acceptable heterosexual love object or it may frighten the adolescent. In the latter instance the adolescent becomes panicky because of his own sexual feelings. He will escape from the adult but with a residual anxiety that there is something wrong with him. In contrast the adult may be frightened by the implications of this aspect of the relationship and reject the young person. This action may lead to concern again on the part of the adolescent, a concern that he has been deserted because he is sexually abnormal. It may also cause him to feel deserted in his time of need, a very painful and disillusioning experience for anyone.

As has been suggested above it is not primarily a sexual drive that leads to this sexual over-lay in a relationship. It is rather that the adolescent has a need for and is seeking a certain type of relationship that will help him work through some aspects of his own confusion.

As indicated at the beginning of this paper, while an adolescent needs an adult to talk to about his inner churnings, he also needs privacy. If he has been able to establish a real relationship with an adult, a relationship of mutual respect and affection, he will discuss his inner thoughts when he wishes. When he does not his inner thoughts may not be bothering him. One of the tantalizing aspects about the adolescent is that at one time he may be struggling with soul-rendering conflicts. Only an hour later he may indicate that his only investment of intellectual and emotional energy is in who will win the World Series or whether he should have a glass of ginger ale or an apple. To ask him at that moment to share a deep exploration of the social meaning of the abuse of the underdog is to invite his contempt and the withdrawal of his faith in you. You to him have revealed yourself as a person who wants him to be a screwball, when, after all, all he wants is to be just like everybody else and have fun in a real world.

The restriction of his interest to everyday activities may be real. It may be a defensive maneuver. In the latter event his thoughts may be actually disturbing him. But at this point he is either not ready to face their details himself or is not ready to expose himself to the scrutiny of another person. Privacy protects the adolescent from the possibility that by facing his conflicts he will be overwhelmed by them and/or be exposed to what to him would be humiliation, regardless of the receptiveness of an adult. An adolescent who lives primarily in the privacy of his own thoughts and who evidences signs of real psychological difficulties may have to be exposed to a violation of his privacy. Such measures, however, should be instituted only directly by or under the supervision of someone trained to treat the disturbed adolescent.

This rather theoretical discussion of the adolescent would seem to have direct bearing on the role of the occupational therapist. While the more generally defined role is applicable to work with the adolescent as with any age group, there is a somewhat unique aspect as far as work with the adolescent is concerned. In general the adolescent does not usually seek out an unknown person for help. He is much more apt to reveal his inner needs and inner turmoil to people he has come to know through activities that are not too personal. Through this association he comes to respect and like the other person. Then when he wishes help, if the person is available, he reveals himself.

Furthermore many of the maturational tasks the adolescent must achieve he accomplishes not by self-exploration but by experiences with others. For a boy to have an enjoyable time with a woman occupational therapist, finding that she does not personify all the awful things he's built up against women, finding that she can be friendly, value him and yet not try to arouse the sexual feelings he fears, can do much towards reshuffling his attitude toward the opposite sex. To play a game with an adult who enjoys winning, tries honestly to win but is not disturbed by losing, can be an extremely significant experience for this age group.

The tools the occupational therapist's professional training provides can be very valuable in working with the adolescent if they are used not as an end in themselves but in order to enable the adult to be one source of help to the adolescent through these tumultuous years.

In this paper adultness has been stressed. This suggests a professional problem. When is a professional person adult?

Adulthood is characterized by the capacity to tolerate, look at, explore and reach conclusions, subject to later modification, about a multiplicity of ideas. The difference between adolescence and adulthood is not the multiple conflicting ideas of the adolescent in contrast with the structuralization of adulthood. The difference is the chaotic diversification without integration seen in the adolescent in contrast to the capacity to integrate

the multiple feelings and ideas that the adult has.

Furthermore, identifying with one's profession and its goals and revealing that identification develops a maturity in a person that may not be demonstrable in other areas of his life. In our work it is the professional self that functions. It is also our professional self that the people with whom we are working see. A nurse, an occupational therapist, a physician may be chronologically younger than their patient but to most patients they have the wisdom and maturity of their profession.

A realization of this response to a professional person is particularly important in dealing with adolescents. The people working with them may be only slightly older; they may be still aware of the residuals of their own adolescent striving and as a result they may feel unequal to the task of being an adult figure to the adolescent. It is the people who can still recall their own adolescence who often are most capable of catching the overtones in the behavior and verbalization of the adolescent.

Adolescents often have more faith in a person who appears to be closer to their own age. This is true only if that individual gives evidence of having attained some internal harmony. It is certainly not reassuring if a sixteen-year-old can find evidence of such internal harmony only in people of fifty. From sixteen to fifty represents too great a passage of time. Thus the young professional person can be the adult figure to whom the adolescent responds if the former has a real professional identity irrespective of what his other roles in his private life may be.

This places a certain burden of introspection upon the adult.

Not only is the young professional person able to identify with the adolescent; he is also subject to having conflicts he thought he had previously solved return to full activation under the stimulus of the adolescent's revelation of his own conflicts. At such a point the adult's professional role can become a cold defense against dealing with his internal turmoil unless he is willing to look at that which has been reactivated in him. For example: an adolescent mobilizing his anger at his mother, may seem to be an echo of the occupational therapist's own past. To avoid facing the return of the past the occupational therapist may try to use his "professional" role, indicating in so doing that this is a topic one does not discuss. A little painful retroactive introspection however may result not only in tolerance for the adolescent's justified irritation at the mother but also a little tolerance for the mother.

Having taken the adolescent and ourselves this seriously, a final word is important to complete the picture. It is fun to work with adolescents.

THE ROLE OF THE OCCUPATIONAL THERAPIST IN NATURAL DISASTER SITUATIONS

MYRA L. McDANIEL, Lt. Col., AMSC

This is the second national conference at which the role of the occupational therapist in a disaster situation has been discussed. The subject was also discussed at the American Hospital Institute in Boston and at the midyear meeting of the American Occupational Therapy Association in Denver, Colorado. It is essential that we continue to stress the role, responsibilities, and duties which should be assumed by the occupational therapist at a time of disaster.

Abraham Lincoln said, very aptly, "You can't escape the responsibility of tomorrow by evading it today." Thus far it seems that some of the occupational therapists have evaded the problem very successfully. Some occupational therapists have not had the opportunity to cope with the problem, as the hospitals in which they work have had no disaster plan in which they could participate. Others have not been recognized in their hospitals as having any potential for assisting professionally in a disaster situation.

Major General James P. Cooney, formerly deputy surgeon general of the Army, has classified people involved in disaster into five major types — the overly optimistic, the very religious, the fatalistic, the ultraneurotic and the sensible. The optimist is convinced that whatever is going to happen to him is all for the best. The very religious type dismisses the problem, too, by declaring, "let God's will be done." The fatalist believes he is safe until his number comes up, and there is not much he can do about it anyway. The ultraneurotic person may even go out and commit suicide to keep from being harmed by the atomic bomb. The sensible type is the only one who takes a positive approach to the problem. He attempts to plan ahead and to learn everything possible to protect himself and others in the event disaster should occur.

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Since occupational therapists as citizens as well as professional persons should be concerned with preparation for disaster, they should be aware of the multitude of accomplishments in civil defense activities within the past year. A *National Plan for Civil Defense and Defense Mobilization* has been prepared and distributed. Under the terms of Reorganization Plan No. 1 of 1958, the Federal Civil Defense Administration and the Office of Defense Mobilization were merged and a new organization, the Office of Civil and Defense Mobilization, was established in the executive office of the President. It establishes that civil defense is a joint federal-state-local responsibility rather than a federal-state relationship. Prior to this law Congress had held that civil defense was primarily the responsibility of the states and their political subdivisions. The National Shelter Policy has been adopted by the administration and a nationwide capability for detecting and measuring radiation is becoming a possibility. Operational survival plans have been formulated in 38 states and many metropolitan areas. When all plans are completed, they will cover more than 97 per cent of the population. It has been recognized that it takes more than a government to create a strong civil defense. Equally important are people and their own personal preparation to survive. The Office of Civil Defense Mobilization says that every American must know these five things:

1. Warning signals and what they mean.
2. Community plan for emergency action. (This can be interpreted for occupational therapists as knowing their hospital plan in addition to that of their community.)
3. Protection for radioactive fall-out.
4. First aid.
5. The location and function of "Conelrad" on the radio.

It is well to establish a clear understanding as to why occupational therapists should be concerned with civil defense information and procedures. These deal with disaster situations. It appears logical that civil defense preparation cannot be separated from the hospital disaster plans with which the occupational therapists should be primarily concerned. Hospital disaster plans are a part of a total civil defense plan. Civil defense plans for disaster situations, whether they be earthquakes, tornadoes, hurricanes, fires or a disaster caused by enemy attack, call for emergency treatment stations, emergency hospitals and expansion of existing hospitals. It stands to reason that these cannot be set up and staffed without using trained personnel. Thus, any role that the occupational therapists play in hospital disaster plans can undoubtedly be correlated with their role in a civil defense plan. Therefore, it should be borne in mind that the occupational therapists have one obligation: to define and establish their role in a disaster situation and to train for that role. Then let the chips fall where they may, for occupational therapists will then be fully aware of their responsibilities and capabilities.

Disasters occur every year and they dramatically demonstrate the paramount need for preplanning and preparedness. The disasters have shown that hospitals, physicians, paramedical personnel and others must cooperate and function as a team. They have shown that a team plan requires close coordination and integration. Most importantly, disasters have proved that a team needs leadership and this leadership must come from the physician. Actions are now being taken to insure that all physicians prepare to assume the role they must play.

Dentists, too, have been very interested in the role they must assume in emergency medical care. Knowing full well that in the immediate post-attack period the usual dental services will not be required, dentistry is willing to devote its skills and training to any disaster service for which it is qualified. As allied medical workers they realize their need for training and orientation in methods of casualty care.

Professional nurses are prepared in many special fields of nursing, and this has invited concern regarding assignment during emergency situations. They realize that it would be ideal if assignments could be made according to specialized preparation and that this should be done if possible. However, it is recognized that assignments in an emergency will be made according to (1) where the nurses are, (2) what needs to be done, and (3) what they can do.

The National League of Nursing in May, 1959, published the following goal for nurses:

1. To be prepared to function in disasters at a high level of efficiency.
2. To be prepared to teach others how to cope with anticipated situations.
3. To be prepared to cope with post-disaster health problems.
4. To have the know-how of self preservation.

An 18-month project in preparing a plan for nursing education in national defense has just been completed. The objective was to develop curriculum content needed for all types of nursing education programs, including in-service programs in hospitals. Massachusetts General Hospital, Skidmore College, Teachers College, Columbia University, and the University of Minnesota participated in the project. Massachusetts General Hospital developed their curriculum around the diploma and in-service programs; Skidmore College worked on content for basic baccalaureate programs; Columbia University worked on advanced nursing educational programs; and the University of Minnesota developed the curriculum content for basic collegiate and practical nurse educational programs.

Columbia University has stated: "It is recognized that a certain number of nurses should be prepared as specialists in mass disaster nursing, so that they may provide the instruction and leadership in the national program of preparedness for natural or enemy-caused disaster."

The role which is proposed for occupational therapists is that of nursing assistants, but occupational therapists have not unanimously accepted this proposed role. It does not seem wise to expect unanimity for who would expect 5,000 members to agree readily and quickly on a proposal of this type? It must be remembered, however, that this role is proposed not for a few occupational therapists but for all occupational therapists, so that the frequent moves to other climates and other jobs, which occupational therapists do so well and so very often, will not affect their overall contribution to any hospital plan at a time when disaster strikes.

The individuals who have not wholeheartedly agreed to the proposed role have agreed enthusiastically to the preparedness training. It is believed that they are themselves in roles identifiable with supervisory responsibility or roles related to the direction of work activity for those incapacitated by the stress situation. Identity and status seem to be involved in their non-acceptance. The intention of the proposed role is not to change the identity of the occupational therapist but to add to it. The basic premise is that in a disaster situation of any kind, the occupational therapist must not be concerned with status but with life-saving and survival procedures.

Disasters, no matter what the cause, always point up the value of human resources versus the importance and dependability of "things." Materials can be rendered useless or demolished, but the potent force that remains is the human element — a person who can walk about, a person whose mind and hands make rescue possible, a person who can relieve suffering and give solace.

The role which is projected requires that occupational therapists learn survival care or emergency medical care in order that they may preserve life, theirs perhaps, or that of their loved ones. The basic Red Cross first aid course demands 10 hours of one's own time. The advanced course requires but 16 hours. These courses would be a logical beginning. Proficiency training in hospital procedures is a next step.

The role further requires that the occupational therapists investigate their present status in their hospital or institutional plan. It is hoped that their hospital has a plan. It is hoped that it is not locked within a safe or locked out of peoples' minds, and it is hoped that occupational therapists are included in the plan. If they are not included, it is their responsibility to emphasize their potential.

It should be pointed out, however, that any hospital is not going to buy a "pig in the poke." If occupational therapists know what they can do, are sincere in wanting to be trained, and can show that by functioning as nursing assistants they can contribute maximally and effectively, it is hard to believe that any hospital would refuse to train them proficiently.

One of the theories regarding learning is that we learn most effectively in a situation which is anxiety-producing. We should be able to learn, however, because of a vicarious anxiety involvement. It is difficult to see how any professional person could read of the natural disasters which beset our world and not have some question as to what he would have done if he had been there. The unexpected earthquake in Montana should have aroused those occupational therapists who have camping blood in their veins. The article in *Life* magazine was quite comprehensive regarding those tense days and of particular interest was the story of the motel owner who had a prepared disaster plan which he put into effect immediately and moved his family and guests to safety.

If one has no camping instincts, there are other disasters to furnish food for thought. What of the man who threw the home-made bomb into the school yard, killing himself, his son and others? What of the school fire in Chicago? Disasters aren't selective of their victims, their place or their timing.

People have said and continue to say, "Why prepare, why stress training when the literature reveals that even a trained person goes to pieces under stress?" This is the exception and not the rule. We know that automatic responses learned through training enable most of us to perform effectively at the time we need to. In May, 1959, a windstorm hit Ann Arbor. The University of Michigan Medical Center tested their disaster plan and 400 doctors and nurses were ready in 30 minutes and they could have treated 200 casualties within one hour.

The occupational therapist's background contains an abundance of professional knowledge which not all members of the medical team realize. They know something of medicine, psychiatry, surgical conditions and have an understanding of the problems pertinent to the pediatric and geriatric groups. They know administrative procedures and are cognizant of hospital policies and regulations. They evaluate, they test, they record. They are versatile, imaginative and many times have great ingenuity. They are, for the most part, accepted individuals in the regular daily routine of the hospital. But in what role does the hospital think of them when this routine is disrupted?

In the various drills that hospitals throughout the United States have held in the past year, the

service, personnel and procedures which will be needed in a hospital during an emergency have been fairly well defined. These include:

1. Get personnel on duty. (Disasters don't observe working hours).
2. Triage—the receiving and sorting of casualties.
3. Special wards for shock, burns, the expectant ladies and the victims who have been classified "delayed treatment."
4. Bed control officer.
5. Operating rooms.
6. Ambulant casualty care.
7. Litter bearers (4 man team found most effective).
8. Supply procurement and distribution.
9. Medical records to include preparation of emergency medical tag.
10. Storage of patients' clothing.
11. Collection of patients' valuables.
12. Traffic control—keeping people out.
13. Public information.
14. Pharmacy.
15. X-ray.
16. Laboratory.
17. Blood bank.
18. Communication—phone, radio net, messengers.

The hospital is a small community of its own. The occupational therapist is generally included on an organization chart, but in an emergency situation, for instance, one fostered by an ordinary disaster, where do occupational therapists fit?

Can they take blood pressures?
Can they bandage?
Can they treat shock?
Can they splint an extremity?
Are they familiar with prepartum care?
Are they familiar with rescue breathing?
Can they give an injection?
Would they be effective in *Central Materiel?*
Do they know what is essential information for the medical record?
Do they know how to apply a pressure dressing?

These are not idle questions. Some of the roles which have been suggested for occupational therapists include operating a switchboard, serving as a receptionist at the information desk, serving as a messenger, assisting on the pediatric ward (this is a valid suggestion).

The medical knowledge and experience of the occupational therapist should not be wasted. The role which is projected, that of nursing assistant, requires competence and proficiency in such selected areas as

Survival care (life-saving and life-preserving measures), and in the care of the injured, which should include treatment of wounds, observation of symptoms, measuring vital signs, administration of medications, administration of injections, application of casts and splints, pre-and post-partum care, pediatric service and care of disturbed persons.

In disaster function, it is believed that occupational therapists should not entrap themselves with administrative or nonprofessional staff duties, but should serve in a professional capacity with the members of the medical team with whom they work on a day-by-day basis. It is imperative that it be understood that these individuals cannot function effectively for hours or days without meals and rest. In an emergency, more hands and feet and knowing heads will be needed than at any other time.

Planning for community survival must necessarily depend upon survival of the individual. Apathy, stupidity and procrastination can be the cause of more casualties than the initial disaster. To preserve our birthright of life, liberty, and the pursuit of happiness, trust cannot be placed solely in groups, governments or in the preparedness of others. Occupational therapists, as individuals, must plan and prepare themselves intelligently. They must do this with dedication and foresight.

This special issue is devoted to digests of the speeches from the 1959 annual conference of the American Occupational Therapy Association held in Chicago last October and to the program of this year's conference to be held in Los Angeles November 10 to 17. More details of the coming conference will also appear in the September-October issue but the preliminary program as listed on pages 227 and 228 shows the excellent schedule for the week. It will be a conference one should not miss. Future projections that will be formulated at this meeting will have a profound effect on occupational therapy. Plan to attend and have a part in formulating our future concepts.

BASIC RESEARCH METHODS, STATISTICS AND DECISION THEORY

O. HOBART MOWRER, Ph.D.*

There is a common supposition that scientific inquiry or research is a kind of never-never land into which only a chosen few may venture. Actually there is a broad continuity between science and the processes by which we make ordinary discoveries and form the opinions which guide our common, everyday actions. In fact, we can even go so far as to say that science is just a refined, sharpened form of curiosity and common sense and that the way to understand specialized scientific methods in their more complicated forms is to see clearly their relationship to ordinary experience.

Everyone is interested in learning, as we say, "what it is all about"; that is, what causes what, and how, therefore, one can produce desirable events and avoid undesirable ones or, when that cannot be done, at least prepare for them. So this, then, is where science starts and, for that matter, ends: in *the study of cause-and-effect relationships.* And most of my remarks will have to do with those devices, procedures, and methods which have been worked out whereby this type of study can be made particularly penetrating, efficient, and convincing.

It used to be felt that these so-called scientific methods were beyond most professional persons and that if you wanted a special study made of something, you had to call in a crew of experts from the state university or specialists from a technical consulting service of some sort. It is true that just as there is power in research, there are also pitfalls. We still need the experts and specialists to help us avoid these pitfalls and to develop new methods for us. But what ought to be particularly emphasized is that if you are interested in doing research, you should not be inhibited by the apparent difficulty and complexity of what you need to know or have in the way of physical equipment. Research potential, one might say, is more a frame of mind or an attitude than it is either special knowledge or equipment. Someone has said that all you need to start a "laboratory" is a toothpick and a rubber band. And although research methodology is endlessly fascinating and rich in ramifications, you can begin research with very little special knowledge or equipment, and learn on the job.

Within the last year or two I have been much impressed by the extent to which this sort of thing is already being done. I like to call it "grass-roots research." And I believe we are going to see a lot more of it. About this time last year I was asked to speak one evening to a group of high-school principals, teachers and school-board members who were spending the week end at Pere Marquette Park, near St. Louis, at a meeting specifically designed to give them training in do-it-yourself research. This past summer I made three trips to New York to attend meetings of a committee which has been set up by the Religious Education Association to help that association and other religious groups in this country learn how to do their own special studies and research. The scheduling of this session this afternoon is testimony of the interest of your own organization; and if we only knew more completely what is happening the country over, I believe we would find many similar expressions of interest in this sort of thing. With these introductory observations, let us now settle down to the task before us and see if we can do a little "research" on research.

CAUSATION AND CORRELATION

There is, of course—as you can readily appreciate—a difficulty in knowing where to start. We should, first of all, observe that research may take either of two general forms: (1) studies or investigations of a naturally existing situation and (2) so-called experimentation. The distinction, if not immediately clear from the terms themselves, can be accented by noting that in the first type of research there is no artificial manipulation of the situation, whereas in the second type of research, i.e., in experimentation, there is. Let me illustrate. Last summer the research and special studies division of the United Community Council of Champaign County, here in Illinois, prepared a set of questions concerning which members of the council's volunteer bureau interviewed selected members of the staff of the University of Illinois, which is located in Champaign County. Last year, and for several previous years, the United Fund drive did not reach its established goals; and since the University is the county's biggest "business," it seemed desirable to at least start the study of this problem with persons employed by the University.

Here, obviously, there was no attempt to manipulate or change anything and "see what would happen." It was just a study, a systematic inquiry or investigation into the situation as is.

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Some interesting findings nevertheless came out of it. For example, although University staff members, together with the community at large, have not been supporting the fund very well, the great majority of those interviewed are in favor of the United Fund approach. This, of course, is just a fact and one which, to be sure, is useful to know; but it doesn't, by itself, *explain* anything. However, there were other questions which were designed to get at explanations, or causes. For example, one such question was: How long have you lived in this community? Although not known to the interviewers themselves, the person in charge of the study had access to information on how much each of the persons interviewed had contributed to last year's fund; so it was easy for him to compute the *correlation,* or co-relation or co-variation as it is also called, between length of residence in the community and size of contribution to the fund. The supposition, or hypothesis, had been that perhaps one reason why University people (and perhaps others) were not supporting the fund was that they move around so much that they don't get interested in their community and fail to become deeply identified with it. The findings —within the limits of their reliability—show that this hypothesis is not valid, or at least not valid in any simple and direct manner. And this, too, was important and useful to know.

You are, of course, all more or less familiar with this type of survey, poll or interview study. For many purposes it can be quite valuable; and as already indicated, the main statistical device used in connection with it, in addition to simple averages and percentages, is the technique of correlation. If there is *no* relationship between two variables, then the coefficient of correlation will be 0.0 or very nearly so. If, on the other hand, the relationship is very high or nearly perfect, the coefficient of correlation will approach + 1.0; and if the relationship is strongly inverted or reversed, the coefficient of correlation will approach — 1.0. Thus, in correlation we have a very convenient and easily understood device for showing the "degree of association" or connection between two variables in a situation. The fact of covariation or correlation, in and of itself, does not, of course, necessarily prove that there is a causal relationship between the variables investigated or, if so, what is cause and what is effect; but on the basis of common sense, or additional investigation, this can usually be figured out.

While the statistical technique of correlation is easy to grasp and not too difficult to carry out in practice, it should not be supposed that it is limited to the uses I have illustrated. It can be extended to provide the basis for a very intricate procedure known as factor analysis which you will eventually want to learn about if you go into research; but you can do a lot of research without ever running a factor analysis. For example, I myself have never done a factor-analytic study, and don't suppose I ever shall. But I understand at least the rudiments of the method, know what its special applications are, and where I would turn if I wanted to learn more about it. This is perhaps all you will ever wish to know about it; or you may find that it is just the thing for some study which interests you particularly, and so you may wish to become something of a factor-analytic expert.

EXPERIMENTATION: CONFOUNDING AND CONTROL

Now for the business of experimentation. Here the distinguishing feature is the deliberate and controlled manipulation of some one variable (known as the independent variable, or cause) and the careful observation and measurement of the resulting change, if any, in another variable (known as the dependent variable, or effect). Described in these formal terms, experimentation may sound somewhat forbidding. But again I think an example will help. Mrs. Violet Fry, a member of AOTA, is currently engaged in what she calls "The Minnesota Follow-Up Study" of "predischarge planning and community follow-up of psychiatric patients discharged from the Moose Lake Hospital and returning to St. Louis County," one of the more specific objectives of which is: "To determine whether a period of special planning for a state mental hospital patient's discharge, begun at the time of his admission, will significantly affect the quality and duration of his post-charge adjustment.

Here is an experiment, the independent variable being the special planning for the patient's eventual discharge, "begun at the time of his admission," and the dependent variable, or effect, being "the quality and duration of his post-discharge adjustment." In other words, the study is designed to ask and, hopefully, answer the question: Can a mental hospital improve its patients' chances, after discharge, of going home and staying there, by deliberately planning for this eventuality throughout the period of hospitalization? Someone, on the basis of his own informal "experimentation" or, perhaps, just on the basis of a "hunch," presumably evolved the hypothesis that predischarge planning will materially help patients in their post-discharge adjustment; and here is an attempt to test this hypothesis, as we say, experimentally. So, despite the terms which I used a moment ago, we see that the basic features of experimentation are not so formidable, after all.

Now let us push on a little further into the matter, and ask: But why perform a so-called experiment? If someone thinks the procedure described for preparing patients for their postdischarge adjustment is good and useful, why doesn't the hospital shift over to it completely and immediately, without fiddling and fooling around with "research"? I think you will anticipate the two major considerations which are involved here. In the first place, some of the hospital staff—including perhaps the superintendent—may not be convinced of the validity of the idea. They want to see it "tried out," on a smaller, experimental scale before it is generally adopted. Therefore, the possibility of giving the idea a "dry run," without too much expense and effort is an appealing one—and an important feature of certain types of experiments, including the one under discussion.

In the second place, if the whole hospital changed over to the new procedure, without carrying out the experiment, the staff might lose the opportunity to find out whether the new procedure was really helpful or not. That is to say, there would always be the possibility that something else might occur about the same time that this change took place, to which the observed improvement (or, conceivably, worsening) in patients' post-hospital adjustment might equally well be attributed. For example, suppose that at the same time that the new procedure was put into effect, the state legislature materially increased appropriations for general patient care, staff salaries, etc. And suppose that subsequently there was a decrease in the rate of relapses and hospital re-admissions among discharged patients. It would obviously be impossible to tell whether the new planning procedure produced the observed effect or the change in financial support available for general hospital operation. This is what is known as confounding; namely, the simultaneous presence and operation of two (or possibly more) independent variables, so that if a change, either positive or negative, is observed in the dependent variable, it is impossible to tell whether it is due to the one or the other of the two independent variables or, quite possibly, to their combined effect or interaction.

This possibility of confounding explains why an experiment is always conducted with a control group or, in agronomy research, the so-called check plot. If only the deliberately introduced, experimental variable is operative in the situation, then its effects, if any, will be seen in the experimental group and not in the control group. Therefore, the outcome will be clean, unambiguous. And if some other general influence happens to impinge upon the total situation then the experimental and controls groups will presumably be equally affected by it and the effect of the experimental variable, if any, will still be differentially reflected in the two groups.

Therefore, in keeping with good research practice, Mrs. Fry's study has a control group, namely, a group of patients who will not be exposed to the predischarge planning but who in all other respects will be as comparable as possible to the patients who will serve as subjects in the experimental, or treatment, group. A control group, incidentally, is often also referred to as the no-treatment group, because the independent variable which is being studied is withheld with respect to it.

Although generally useful, as experience has shown, the experimental method is not, however, by any means foolproof. When human beings are involved, there is, for example, always the possibility that the observed results, if positive, are due to the so-called Hawthorne effect, that is, the tendency for subjects to "do better" merely because something special—it doesn't much matter what—is being done for them. And conversely, if human subjects know they are in a control group, they tend to show disappointment and apathy because of the impression that they are missing out on a good thing. Actually, when an experiment works out negatively, having been in the control group is an advantage to the subject, rather than a disfavor; but the general tendency is to be pleased to be in on "something new" and to be disappointed otherwise. In pharmacological research one can check for the true effects of a drug by giving control subjects a placebo and making them think that they, too, are getting the "treatment." In much other research however, including the Fry project, there is no comparably simple way of handling this problem.

Also, there is always the question of how reliable the results of an experiment are, statistically speaking. We shall return to this problem shortly, but first we should look, at least briefly, at recent developments in research design itself.

FACTORIAL DESIGN AND INTERACTION

For reasons which we have already reviewed, the maxim has grown up that in experimentation you must allow only one variable to operate at a time. Otherwise, as we have seen, there is the very real danger of a confounding of causes and resulting ambiguity as to what has really produced the observed effect. But, somewhat paradoxically, a group of agricultural researchers, working in England about 25 years ago, discovered that there are, in fact, certain very real advantages in studies wherein two or more independent variables are investigated concurrently. Superficially, this looks like a violation of the

established practice of allowing only one variable to operate at a time; and in one sense it is such a violation but, as we shall see, to good effect. In another sense, however, we shall see that this principle is still observed quite meticulously and that there is a resultant increase, rather than decrease, in the total amount of precise information thereby obtained.

It will be useful if we introduce some simple diagrams as an aid to our exposition. In these we shall use small squares to represent different experimental procedures. This practice first arose from the fact that in the agricultural experiments referred to, such squares originally repre-

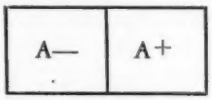

Figure 1. A way of visualizing a simple experiment of conventional design. The cell or "box" on the right represents the experimental group (or, in agronomy, plot); and the cell on the left represents the control group (check plot.) "A" stands for the independent variable, whose effect on some dependent variable is under investigation.

sented experimental and control plots of ground, and therefore were an aid to visualization. We shall see that the same schematization can also be used to represent groups of human or animal subjects or physical specimens of some sort equally well.

Let us begin by depicting an experimental group, or piece of land, by means of one square and place next to it a second square to represent the control group, or check plot. Now we are, of course, going to be interested in studying the effect of some independent variable upon some dependent variable. Let us say, for sake of clarity and simplicity, that we are going to perform an experiment on the productivity of field corn and wish to study, specifically, the effect of a particular fertilizer, which we may designate by the letter A. We will show A as present (A +) in the experimental plot or cell of our diagram and A as absent (A—) in the control cell (Figure 1.)

This is merely a graphic representation of a conventional, uni-variate type of experiment. Suppose that we also wish information on the way in which the yield of corn is influenced by the time of planting. If we followed the conventional procedure, we would have to do another, independent experiment. We would again need two areas or plots, in one of which we would have early planting, which we will identify by the notation B +; and in the other, late planting, which we will identify by the notation B— (Figure 2.)

Now a little reflection will show that, in the

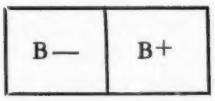

Figure 2. Essentially a duplication of Figure 1, except that a different independent variable, or possible cause, is under investigation, i.e., variable "B" instead of "A." Here, as in Figure 1, the plus and minus signs are used to denote, respectively, "present" and "absent."

example under discussion an economy in both land and labor can be effected by combining these two experiments to the extent of employing a common check plot. At first this may not seem possible. But then we remember that when we do Experiment One, Variable B must be either present or absent in both the experimental and the check plots; and let us say that we decide that B shall be absent, so we can now add B— to both of the cells in Figure 1. And, likewise, when we do Experiment Two, we shall have to have Variable A either present or absent in both of the plots; and let us suppose that we again decide that it should be absent. Therefore, in like manner we can add A— to each of the cells shown in Figure 2. Now we make a discovery: the check plot in Experiment One is exactly like the check plot in Experiment Two. So why not eliminate the Experiment-Two check plot and make the Experiment-One check plot do double duty, as shown in Figure 3?

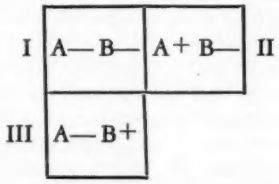

Figure 3. A research design involving a common control group, or check plot (Cell I.) Here the same amount of information is obtained as from two separate experiments, involving four plots, or groups, rather than only three.

Because our terminology would otherwise become a little unwieldy at this point, let us attach the Roman numerals I, II and III, to the three cells shown in Figure 3; so we can quickly note that Cells I and II differ only with respect to the absence or presence of Variable A, and so are directly comparable with respect to the effect of this variable; and that Cells I and III differ only with respect to Variable B, and are likewise directly, and unambiguously, comparable with respect to the effect of this variable. Here we get the same amount of information from three cells as we would, in two conventional-type, independent experiments, from four cells, and so effect a labor and land saving of 25 per cent. This is the technique of the common-control

group and has long been recognized and accepted as legitimate.

However, R. A. Fisher and the other English research agronomists already mentioned saw a new possibility in this situation. How would it be, they asked, if one "filled in" the diagram shown in Figure 3 by the addition of a fourth cell in which A and B would both be present and operative? This arrangement is shown in Figure 4. For the moment we have lost the

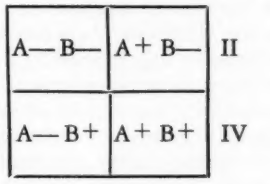

Figure 4. A factorially designed experiment, having the various advantages described in the text. The development of this type of research design is particularly associated with the work of R. A. Fisher.

advantage of the 25 per cent saving in land and labor, for we are now back with four plots again, rather than only three. But we obtain from such an arrangement a kind of information which we would never get if we studied the effects of A and B in two separate experiments, as shown in Figures 1 and 2, or for that matter, as shown in Figure 3. In Figure 4 we have again, as already noted, reverted to the use of four plots; but in the fourth one we have something which does not appear in any of the four plots shown in Figures 1 and 2, namely, the combined operation of both Variable A and B. It may be that, in our hypothetical experiment on field-corn productivity, neither fertilizer A, without early planting (Plot II), nor early planting, without fertilizer A (Plot III), will improve yield but that the two of them, operating together, will do so. If so, we will discover this from the design shown in Figure 4, whereas we would never get this information, from the same amount of land and labor, if we used the two separate experiments shown in Figures 1 and 2. In other words, by what Fisher called the factorial design of experiments (not to be confused with the technique of factor analysis, mentioned earlier), one can study the interaction of variables, which in some situations is crucial.

But then other advantages of the factorial design of experiments, which we can only allude to here, were also discovered. If, for example, one is working with wool productivity in sheep, one will obviously not be using different plots of ground but groups of sheep. And if one now also wishes to study the effect of two independent variables, A and B (e.g., the presence or absence of a given kind of vitamin in the sheeps' food and indoor shelter or the lack of it during the winter months), one can obtain, by means of a factorially designed experiment, the same amount of basic information from, let us say, a total of 100 sheep (25 in each cell, or group) as would be obtained in two separate, conventional types of experiments with a total of 200 sheep (i.e., 50 to a cell or group), plus evidence on the question of interaction, which the usual kind of experiment will not provide at all (refer back to Figures 1, 2, 3 and 4.) These, obviously, are substantial advantages which, when combined with the fact that this type of research design also permits the use of a statistical procedure known as the analysis of variance, make the factorial design of experiments very attractive and advantageous indeed.

This, unfortunately, is as far as we can pursue this topic; but you will find R. A. Fisher's book, *The Factorial Design of Experiments*, a fine guide for further study.

SPONTANEOUS VARIABILITY AND TESTS OF SIGNIFICANCE

Let us now return to the question, alluded to earlier, of how one evaluates findings statistically. And let us begin by noting that the need for statistics arises from the fact of so-called spontaneous variability in the dependent variable. Suppose that one has constructed a "machine" which functions like an ordinary spring balance or scales. And what one now wishes to find out is whether a given piece of lead, placed on the pan of the scales, will cause the pointer to move. If the scales are in good order, we find that this does occur; and, what is more, the piece of lead always causes the pointer to move by almost exactly the same amount. This is because there is no spontaneous variation, or "noise," in the system; i.e., when one applies the lead, as cause, the effect is perfectly clear and unambiguous. With no random variability in the dependent variable, or scale reading, there is no need for statistics.

But let us now suppose that the pointer fluctuates a good deal, regardless of where it is on the scale; so that if we now apply the piece of lead and the pointer moves, let us say, to the right, we cannot be sure whether this is a true effect of the placement of the lead on the scales or whether it "might have happened anyway." Here we need statistics—or something—to help us interpret our observations.

I hope this illustration will not seem too contrived to you. I use it because of its simplicity. Let us now return to the Fry study for a more realistic type of example. As this study progresses, it will, of course, be found that not all persons in the experimental group make an equally good adjustment in the postdischarge period and

that persons in the control group will likewise not make an equally good postdischarge adjustment. In other words, there will be variability in goodness of postdischarge adjustment in both groups which is produced, as we say, by so-called "extraneous factors," i.e., independent variables or causes other than the one in which the study is particularly interested and over which the investigators have no adequate control. Here is where statistical procedures are needed.

As a deliberate over-simplification, let me say that when there is a lot of spontaneous variation of the kind described, one might, just by chance, come up with a group of individuals in the experimental group who, on the average, made a better postdischarge adjustment than did those in the control group, not because of the action of the experimental variable, but because of what is often called an "error of sampling." That is to say, the effect is obtained, not because of the special treatment given to the experimental patients during their hospitalization, but because of an accidental selection of subjects for the experimental group who, for other reasons, were going to make a good postdischarge adjustment anyway.

So recognizing the possibility of this kind of situation arising, as we say "by chance," we would very much like to know, if we can, just how serious such a possibility is, i.e., just how likely or probable it is that one would get a difference of the magnitude actually obtained if the experimental variable were not really effective and the obtained difference were due entirely to accidental, or random, variations of the kind described. (This, incidentally, is what is known as testing the *null hypothesis,* i.e., the hypothesis that the variable under investigation does not make a real difference, does not have a real effect upon the dependent variable.)

Statistical procedures have been worked out for providing estimates of the kind desired in this connection. For example, one can apply what is known as the *t*-test and find what the probability is of obtaining a difference of a given magnitude between the average performance of the experimental group and of the control group if chance alone were operating. In other words, if by such a procedure, one obtains a P (for probability) of, let us say, .04, this would mean that if chance alone (i.e., spontaneous variability) were operative, one might expect to obtain a difference between the means as large as or larger than the one actually obtained only four times in 100 repetitions of the experiment.

Such a P-value, of .04, would thus seem to be "pretty good." And, for example, a P-value of .15 or .25 would not be re-assuring at all. But where do we "draw the line," between experimental findings which are reliable, trustworthy, significant, and those which are not? Attempts have sometimes been made to establish conventional cutting points, or limits, at the .05 or .01 levels of significance. But if, in an actual experiment, a P-value of .04 were obtained, this value would be reliable or significant by one of these arbitrary criteria but not by the other. So what is one to do? How is one to know whether to use the one or the other of these "cutting points"? Does this ambiguity mean that it is useless to compute and report the P-value of the difference between two means or averages? Not at all. It may be very helpful to others to know what P-value was obtained in a given study; but we should abandon the idea that there is any way of arriving at a specific value of *P,* beyond which all results are reliable and below which they are not. The truth seems to be that one evaluates a P-value in terms of what one proposes to *do* on the basis of the findings. And this consideration leads us, to our final topic, which is so-called decision theory.

DECISION THEORY: MIND OR MATHEMATICS?

It should not of course be assumed that in the preceding section we have exhausted the topic of "tests of significance." There is a large literature on this subject which you would very possibly find interesting but also, I venture to predict, somewhat self-contradictory. And the basic reason for this confusion is a misconception or exaggeration of what such tests are really good for.

At the week-end workshop on educational research at Pere Marquette Park which I mentioned earlier in this paper, I asked the group at one point just what it was that they expected statistics, and more particularly tests of significance, to be able to do for them. One woman in the group, apparently with considerable support from the other persons present, said "We expect statistics to tell us what to do." I regret to say that some writers of textbooks have encouraged this expectation, but it is gravely misleading. Suppose you perform an experiment and obtain a P-value of .04 for the difference between the means for the experimental and the control groups. The fact that this value is greater than .01 and less than .05 tells us nothing whatsoever as to what we ought to do about the findings.

Suppose that the research which Mrs. Fry and her associates are carrying out, on the effect of predischarge planning on postdischarge adjustment, produces a P-value of .04. Does this mean that the hospital ought, automatically and immediately, to adopt predischarge planning as a general policy throughout the hospital? Not

at all. In common-sense terms, we would say that the decision to do or not to do this would depend on many considerations which have little or nothing to do with the experiment itself. Would the present staff really understand and be sympathetic to the new procedure? Would the anticipated gain in patient postdischarge adjustment be sufficient to warrant the extra expense involved? And so on. The decision, one way or another, would in the final analysis obviously be a matter of "judgment." And judgment is always subjective, a matter of the values one has. Decision is ultimately a matter of human volition or choice; and although tests of significance and other statistical devices can help us arrive at wise decisions, we cannot expect statistics to make the decisions for us. If we follow some arbitrary formula or rule and assume, for example, that we should act upon all P-values below .05 and never act upon P-values above this level, we are likely to accept some findings which we should have rejected and reject some that we should have accepted. For some purposes, a P-value of, let us say, .10 is quite "good enough," whereas for other purposes we may rightly insist upon a P-value of .001 or even smaller. As the saying goes, "it all depends." And the human mind is the best device thus far discovered for taking all these dependencies and contingencies into account and arriving at a conclusion which, although not invariably sound, is quite likely to be so.

Again there is a large and rapidly growing literature on so-called decision theory; but I believe, for the moment, you can spare yourselves the trouble of trying to read very much of it. The fact is, there is no possible way of avoiding the pain and travail of making decisions; no formula or machine can do this for us.

PARTING ADMONITION

I hope I have succeeded in diminishing, at least a little, any feeling that you may previously have had that research is not for you. The rudiments of this field are not at all difficult to grasp; and if you, personally, do not have the time or inclination to do the additional study that would be necessary for the execution of a given study, you can always get an assistant or consultant to help you out.

Research, in addition to being scientifically and socially useful, is fun. I commend it to you in the highest terms. But I think one of your own members—again I am referring to Mrs. Violet Fry—has expressed better than I can the thought with which I wish to leave you, when she says:

"We are aware that this is a departure from our usual activities, but we also foresee a broad field of expansion for our profession. If we are to continue to grow and to take the initiative in promoting our contributions to medicine and society, we must step forward confidently and positively to prove ourselves capable and worthy to take our place in the field of research. In our case we have gone beyond the clinic wall and rightfully so. We have given the challenge and are striving to make occupational therapy a concrete part of the research team."

More power to you, Mrs. Fry, and all the rest of you.

INTERNATIONAL PROSTHETICS COURSE

The New York University Post-Graduate Medical School is offering a series of two-week courses in prosthetics in cooperation with the International Society for the Welfare of Cripples, just prior to the eighth world congress. Separate two-week courses for physicians and surgeons, therapists and prosthetists will be offered, each meeting from August 15-26, 1960.

Course No. 742-I for physical and occupational therapists will include pre- and post-operative care, prosthetic components, biomechanics, fitting and alignment principles, prosthetic evaluation and training of both the lower extremity and upper extremity amputee. Special attention will be given to the analysis of amputee performance, methods of prosthetic training and correction of problems.

The courses will include laboratory sessions with amputee patients to afford practical experience in applying the material covered in the lectures and demonstrations. As time permits, a number of sessions in the field of lower extremity orthotics (bracing) will also be included.

RESEARCH POTENTIALITY OF OCCUPATIONAL THERAPY

MARY REILLY, Ed.D., O.T.R.

Introduction

Most professions which model themselves along medical lines take pride in the growing scientific nature of their practice. Practice today in any field depends upon the knowledge which the various scientific fields have developed and relies, particularly, upon the methods of science which are used to deepen technical understanding. The same critical rational spirit which is moving and directing other health service professions is stirring in occupational therapy. We have known for a long while that because of the environment in which we practice, and the aspirations which we have for our profession, we must become "scientific."

The harsh facts of reality, however, are that no group can become scientific by an act of wishing. Before science can emerge in any field, a climate favorable to its development must be created. It is speculated that the nurturing of such a climate for occupational therapy might well mean that: (1) at the clinical level our minds should become dominated by the attitudes and methods of science; (2) at the school level our curricula should contain knowledge both substantive and appropriate to the problems which are the responsibility of our profession to solve; (3) at the administrative level our national association should be so organized that our collective resources could be directed with more validity to the improvement of the occupational therapy service which is to fill the health needs of patients for activity.

Meyerson, fairly recently, in *The American Journal of Occupational Therapy,* was commenting on the basic problem which confronts our practice as a science. He was viewing our clinical behavior with what appeared to be some astonishment, and said:

> No one who has seen a good occupational therapy program in action can doubt that it seems to result in great help for some patients and some help for many. There appears, however, to be no vigorous and comprehensive theory which will explain who is helped, how, by what, or why; and there is little objective evidence that occupational therapy is actually effective. To be sure much of the world's work is based upon "common sense," but the history of science suggests that untested impressions are often wrong and that the most useful knowledge is not simply that something "works" but how it works and why.
>
> Two examples may make this argument clearer. In 19th century France, infants fed cow's milk tended to die much more frequently than infants who were fed a mildly alcoholic grape drink. It was believed, therefore, that wine was a more healthy beverage for children than milk. As every nutritionist today knows, that is not true although in a pragmatic sense, it "worked." It seemed to be true only because wine carries fewer germs harmful to man than unpasteurized milk. Before the discovery of the relevant variable human action was limited to a choice of the lesser evil. Clearly this is not as useful as being able to select a positively healthful beverage.
>
> Similarly, in the 19th century America, farm families allowed cheese to become moldy on the back porch. They used to apply this greenish mold to cuts and wounds in the belief that it facilitated healing. This belief, more frequently than not probably was justified, but there is clearly no comparison between the usefulness of this knowledge and the effectiveness of modern penicillin.
>
> Occupational therapy [Dr. Myerson concluded], to an outside observer, appears to be in the wine and green mold stage of pre-scientific effectiveness.[1]

For the purposes of discussion, suppose we were to accept the Meyerson evaluation that we are in the wine and green mold stage of prescience; and suppose that from this foundation we were to attempt to design our scientific advance. It is proposed that we search out and identify our scientific potential through an assessment of: (1) the thinking process we use to solve our clinical problems; (2) the unique occupational therapy process which we use to help people; and (3) the supporting status of our formal organizations. This discussion will cover the first two processes, because there is not sufficient time to include the third.

THE THINKING PROCESS

The human mind is like a tool which must be disciplined to cut and shape reality for ever improving purposes. We know that the refinement of thinking is the product of a gradual and evolutionary kind of change. We know, too, that the refinement of the thinking process is usually described as an upward spiral of advance which may be detected in a group as well as in an individual. The mode of thought which characterizes scientific behavior is an advanced stage of the upward spiraling of the thinking process. It would seem reasonable that the exploration of the various stages of this spiral could be productive of clues we might use in order to acquire the behavior most conducive to shaping the clinical realities which face us. It would be even more useful, for the purposes of the present discussion, if we could trace this pattern through our occupational therapy behavior.

It is necessary, first, to make some general statement about the reason for the existence of

our practice. Occupational therapy grew from the idea that activity was a potent force in the restoration of health. From the time of our earliest beginning, our thought processes have been directed to the problem of cutting through the reality of activity and its role in health. We began our thinking with the all-inclusive generalization. Our clinical behavior was dominated by such beliefs as: activity is good for all patients; destructive activity reduces hostility; constructive activity, as in carpentry, can improve joint range. Our education supported this behavior by teaching clinical conditions at the level of descriptions of symptoms which could be modified by activities; and by teaching the human systems at the level of structural and functional description which could be learned by rote. Fortunately, we are acting now as if we are aware that generalizations are modifiable and that activity can, with equal effectiveness, reinforce spasticity and hostility.

The next stage of thinking for us was the transition from the all-inclusive generalization to the recipe of the standard operating procedure (SOP.) Standard procedures for paraplegia, amputation, peripheral nerve injury, cerebral palsy, paranoia and psycho-neurosis are highly valued in today's practice. Our behavior is dominated by the belief that a given treatment goal may be achieved under a given set of circumstances. This mode of thought, i.e. the SOP, may have equipped us with many dependable techniques, but it carries with it some serious liimtations. It requires a tremendous investment of time and effort in the acquisition of the many techniques growing out of this approach. Our very "busyness" prevents the emergence of the next advance, which is dependent for its appearance upon raising significant and experimentally answerable questions about activity. The present characteristic mode of thinking is further entrenched by an educational system which concentrates on the immediacy of practice, the transition of facts, and the acquisition of techniques at the expense of penetrating interpretation and student maturation.

A further tracing of our pattern of clinical behavior would lead us directly to the threshold of our search. This is identified as the scientific mode of thought known as the critical form of thinking. It constitutes the analytical approach to treatment and requires that: clinical action be adopted only after the problem has been defined; an hypothesis regarding its solution postulated; data gathered as the hypothesis is tested; and the action resulting is further subjected to analysis as it is carried through. In the field of medicine such a mental process is called differential diagnosis, and the physician is trained to rely on observation, hypothesis and critical evaluation of his actions. In social work the most valued form of critical thinking is called the systematic case study. In nursing, although this field is still largely committed to the standard operating procedure, the nursing-plan, as a form of critical thinking, has started to appear in the literature.

Signs of the occupational therapy approach to critical-analytical thinking are appearing in both the literature and practice. We call it the occupational therapy evaluation. However, our concept of evaluation as a process appears so far to be superficial. Success in the evaluation process will depend upon the skill and the understanding with which we use certain data collecting instruments. These instruments are: (1) The Observation Method; (2) The Interview Method; (3) Testing; (4) The Interest Case History Method. The essence of the evaluation process is the systematic manner in which clinical data are collected, and it is from this systematic action that the treatment plan is derived. The treatment plan, in this sense, becomes the hypothesis upon which clinical action is based. The mental processes of the therapist may then be summarized or symbolized as: $Rx = \Sigma\ (O+T+I+H)$.

When Rx equals treatment plan, Σ equals sum of, O equals observation, T equals testing, I equals interview and H equals interest case history, the treatment plan equals the sum of the related raw data drawn from the data collecting instruments of observation, testing, interview, and interest case history.

In estimating the speed with which critical thinking can emerge in our profession, there are certain strongly interfering and competing forces which warrant consideration. There is a belief current in practice that as busy therapists we cannot stop to take on a new form of behavior. We are overwhelmingly preoccupied with unresolved problems which require new recipes, and we feel a tremendous pressure to extend old recipes over a large case load. To commit ourselves to a program of hyperactivity in the clinical field, and to do so without the regulatory discipline of doubt, leaves our behavior and our value open to question. It would seem that now is the time to remind ourselves that if we persist in being too busy to think, we may grow more dangerous in treatment.

Another barrier to our growth is the possibility that the practicing therapist may, on superficial examination, decide that the data collecting instruments are already present in today's treatment methods—for, after all, who does not observe patients, test them, talk to them, and review the case histories? Whereas, in actuality, these tools have been defined and refined in many other areas of practice and are deserving

of being studied as entities in and of themselves. Their study, moreover, deserves a prominent place in the basic curricula which supports our practice. It is speculated that any attempt on our part to modify these and other barriers preventing the development of critical thinking will bring with it desirable side effects. One of the most important of these is bound to be an improved method of thinking which would enable us to identify the fundamental areas of practice requiring research.

THE OCCUPATIONAL THERAPY PROCESS

For us, in occupational therapy, the most fundamental area for research is, and probably always will be, the nature and meaning of activity. Our profession rests on the unchallenged assumptions that man has a vital need for activity, and that activity enhances convalescence. Basic research must explore these assumptions and in the search there can be no interference with the right to explore into whatever areas good questions lead. As answers to perceptive questions about activity appear, the fundamental nature of our service will emerge and the process of treatment unique to occupational therapy will be identified.

Our approach to the occupational therapy process began with craft analysis. We had faith that the secret of treatment was hidden in the physical and psychological demands of an activity and that this mystery would be revealed in the process of craft analysis. Our attention has gradually shifted to man's need for activity. We have acquired an understanding, at an intuitive level, of man's need to explore the possibilities of surfaces, lines, colors and tones, and upon such explorations to build his later achievements. We are becoming more aware of the fact that the interests of man emerge in the gratification of his senses. In over forty years of practice we have seen that the use of brush and hammer, in the world of the craftsman, provides more than sensory combinations and more than a manual skill. We believe that it yields the satisfaction of activity plus the gratification of using muscles. We now know that whatever benefits are inherent in achieving a goal and a sense of ego fulfillment can be legitimately claimed for occupational therapy. We know, too, that the arts and crafts as the major focus for the occupational therapy process can no longer be defended. The shift has already begun to the exploration of those areas from which an understanding of the human drive for achievement may be expected to be found. New horizons will open for us as we concern ourselves with the growth and patterning of aptitudes, abilities and interests. An exciting search into the meaning that creativity and achievement have for personality development lies before us. We are on the very threshold of developing a theoretical system which might explain and guide the unique helping process called occupational therapy.

Again we must estimate some of the forces currently competing and interfering with the identification of the scientific basis of our service. One of these anti-forces is a policy position on activity being formulated nationally. In 1959 our national association published the proceedings of a conference which studied the relation of occupational therapy to activity.[2] Because it is one of our first major statements regarding activity, it deserves some careful reviewing. The context in which activity is discussed was the psychiatric area of our practice. The proceedings appeared to be a recognition of our failure to cope with the activity needs of a vast number of patients and an acknowledgment of the various groups with activity skills who are filling the need. Each group which had a skill in recreation, manual arts, or music was called, along with occupational therapy, a discipline. No desirable difference was identified between the occupational therapist and the recreation, manual arts or music therapist. As far as rendering an activity service to patients was concerned, the medically dominated occupational therapy curriculum with its period of mandatory internship was equated in usefulness with the general education and physical education background of the other disciplines. It was a major recommendation of this study that the occupational therapy group submerge its professional preparation into an interdisciplinary form of training.

The conference appeared to place a high value on a technical competency in the media being used. In the interests of insuring media competency it was further recommended that the primary function of each discipline be determined by the modality in which the group was trained. Occupational therapy was promised the right to use arts and crafts and, in addition, any activity for which there was no specific discipline available.

The fragmentation of activity into media-centered disciplines which could be formed into a loose interdisciplinary association is the core proposal of the study. This proposal, if taken seriously and moved into a policy position by our national association, would be a direct interruption of the emerging occupational therapy process. It would seriously interfere with the effort to identify the meaning of activity and its role in treatment. It would force the occupational therapist in the psychiatric field to return to a previous state of the all-inclusive generalization which asserts that activity is good for all patients and the more activity a patient has the

more his condition would improve. Furthermore, the recommendations of the study cast the psychiatric hospital in the questionable role of a gigantic house of fun in which country-clubism becomes the desirable milieu for the restoration of emotional health.

Unless occupational therapy resists attempts to fragment the concept of activity before its therapeutic nature has been identified, there can be no science in our practice. Those who have observed the partition of activity by agreement, which is currently going on in some of the federal and state hospital systems, have only to observe the corresponding decay of the occupational therapy service. The heart of the problem, as Dr. Solomon reminds us in the preface to the activity study just referred to, is the proper definition of treatment. It is to this question that our best thinking must be directed. No profession should interfere knowingly with the freedom and atmosphere within our institutions to search out this vital answer. Nor should any profession neglect its responsibility to implement this effort by nurturing in some of its members a basic simplicity of approach, a careful training in the ways of idle curiosity and a spirit of free inquiry. Nor should any group neglect its responsibility to organize its formal structures so as to provide the leadership and support that its scientifically sensitive education and practice demand.

SUMMARY

The potentiality of occupational therapy for research behavior was explored. A certain mental set for treatment was described as a necessary condition. The importance of keeping activity, *per se*, as a free unrestricted area for fundamental research was stressed. The scientific nature of occupational therapy was identified as being on the threshold of emergence.

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A TREATMENT PROGRAM FOR RHEUMATOID ARTHRITICS *

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Arthritis continues to be the number one cripler and it is estimated there are 1,000,000 rheumatoid arthritics in the United States. Approximately 50 per cent improve without any or very little treatment, but for the remaining 50 per cent the disease may have an erratic course. The cause of the disease still is unknown and to date no known treatment has proved adequate.

Within the last ten years there has been a renewed interest in the possibility of a "rheumatoid arthritic personality." Several studies have proposed that the rheumatoid arthritic tends to show a marked restriction of emotional expression particularly in association with hostility and the handling of aggression.[1, 2, 3, 4, 5, 6, 8, 9, 10, 11] It has been suggested by some investigators that the arthritic symptoms represent a means of controlling or preventing the expression of hostile aggressive impulses.[7, 9, 12, 13] Most of the literature dealing with the psychosomatic aspect of the disease have lacked objective data however. There has been a lack of literature directly relating to studies where rheumatoid arthritics have had an opportunity to express or discharge their hostility. Although many authors agree, based on their findings, on the type of rigid personality found in rheumatoid arthritics, there have been no studies carried out and subsequently published in which the release of hostility was encouraged and the physical changes measured.

The purpose of this investigation was to study and evaluate a treatment program in occupational therapy designed to encourage the expression of hostility in a group of rheumatoid arthritics. It was postulated that there would be an increase in joint range of motion and also a significant shift in the increase in adaptability and loosening of emotional rigidity.

From 352 out-patients who attended the arthritis clinic at the Los Angeles County General Hospital in 1958, 20 were chosen for this study. The criteria for the selection of the population were:

(1) Both sexes.
(2) All races.
(3) Age range from 20 to 60 years.
(4) Diagnosis of rheumatoid arthritis on the basis of clinical findings, blood studies, X-rays and classification of measurable changes.
(5) At least a fifth grade education.
(6) Ability to understand and write the English language.

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†Project therapist.

The 20 patients who did meet the criteria were individually given a battery of projective tests by the psychologists on the project and measured by goniometer, dynamometer and hand tracings. Measurements were taken by the project therapist and one therapist not acquainted with the study to avoid personal bias.

The testing and measuring were done prior to the commencement of treatment and again at 16 weeks and 32 weeks. Following the initial testing and measuring the 20 patients were divided into two groups: 10 in the experimental group and ten in the control group. Each of these groups was further divided into two groups. These groups were matched in pairs according to the hostility factor and the degree of involvement.

Medication was kept constant during the treatment period. The patients received up to 32 weeks of treatment: 16 weeks in the first period, 16 weeks in the second period. Eighteen patients completed the first 16 weeks of treatment. Twelve of the original 20 patients completed 32 weeks of treatment in the study. At the start of the second period six new patients were added to make up a total of 20. These new patients did not meet the language and education requirement of the study.

Control Groups I and II received physical therapy twice a week for a maximum of four hours per week. In the physical therapy setting the majority of the patients received pool therapy followed by active exercises. For those who did not receive pool therapy, another passive type of treatment was substituted followed by a period of active exercises.

The Experimental Groups I and II received occupational therapy (specifically designed to encourage the release of hostility) twice a week for a maximum of four hours per week. In the first hour in the occupational therapy setting the patients were treated as a group in a permissive environment. That is to say the treatment area was set up in advance, the patient entered the room and went to the activity of choice. He worked on the same activity for as long as he wished up to a one hour period, or to tolerance, and rested at will. the activities were chosen on the basis that they: (1) necessitated the use of large muscle groups in the upper extremities, (2) were graded for the degree of resistance and (3) were destructive in nature for the release of hostility. These destructive activities included breaking up wood, glass or clay; cutting or tearing of paper, cloth or yarn; cutting or pounding of metal; and wedging or throwing clay.

In the second hour of treatment the same permissive environment existed. The activities were chosen: (1) to use both gross and fine movement of muscle groups in the upper extremities, (2) to provide graded degrees of resistance and (3) to encourage creativeness while hostility-oriented. The creative activities were wood and chip carving; sawing, chiseling, hammering and burning wood; glass or paper mozaics, paper mache, sculpturing in paper or clay; metal moulding and peaning, and copper enameling.

Subjective data was kept on a daily basis. Objective data was analyzed at 16 weeks and again at 32 weeks. The results showed that the experimental groups (occupational therapy) reached their maximum rate of improvement at 16 weeks in this study. The control groups (physical therapy) continued to lose after 16 weeks but at a lesser rate. At approximately the twenty-third week of treatment the experimental groups became much more verbal and their approach to the aggressive activities levelled off and in some instances diminished. The new members of the experimental groups reflected an inability to respond to their environment in marked contrast to the initial response shown by the original members at the beginning of the first period in the arthritis project.

The control groups performed at about the same level in both periods. That is to say that they tended to reject the active phase of treatment, showing preference for the passive phase. The absenteeism rate in the experimental groups was 15 per cent in both the first and second period of treatment. In the control groups the absenteeism rate rose to 30 per cent in the first period and 45 per cent in the second period.

To conclude, in this study it was found that when a group of rheumatoid arthritics were encouraged to express their hostility through socially acceptable channels such as occupational therapy there was an increase in range of joint motion up to the twenty-third week of treatment. At that time verbalization increased which may have indicated a need for a more advanced type of treatment, such as group psychotherapy in conjunction with occupational therapy. The control groups in this study continued to manifest rigidity in that they lost range of motion. They rejected the active phase of treatment in preference for the more passive types of treatment which appeared to meet their dependency needs.

The author would like to express her appreciation to the medical committee for their advice and guidance; to Mrs. Claire Kopp, O.T.R., and Mrs. Anne Akers, R.P.T., for their professional cooperation; and to the patients who comprised the population in this study without whose efforts and interest this study might not have been possible.

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OCCUPATIONAL THERAPY STUDENT RESEARCH PROJECT

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At the Cleveland Psychiatric Institute and Hospital, the occupational therapy department is presently involved in a project relating to the patients' choice of activities. Informally, within the hospital, this study is known as the occupational therapy student research project and rightly so for the students are doing the actual work.

This study was instigated (1) to learn if we have available the activities to meet the patients' needs during the evaluation period and later during the pre-discharge planning period; (2) as a tool to give the student a continuum of experience in and knowledge of the many facets of occupational therapy; and (3) to prepare ourselves for participation in a future research project.

It has been our custom to orient the patient referred to occupational therapy the day previous to his first session. This orientation consists of having the department member who will be working with him call for the patient on his ward and bring him to the occupational therapy clinic. The patient meets all occupational therapy personnel and becomes acquainted with the physical plant. During the next two-week period or for approximately six sessions, the patient chooses from the available activities what he wishes to do. This is an observation and evaluation period for the therapist who subsequently submits reports of the patient's performance to the psychiatrist. These reports are essential to provide a basis for the occupational therapy prescription as well as to aid in arriving at a final diagnosis. This is followed by a treatment phase in which the therapist is more directive in the choice of activity. In the final period, when the patient is being prepared for discharge, he again takes the lead in determining his occupational therapy media.

Our present concern is having available the proper media for the first and third phases of occupational therapy, as well as providing our students with the opportunity to understand the intricacies and need for careful handling of the phases of occupational therapy. We have devised an investigative study which they, with the help of a supervising therapist, carry out during their entire affiliation. Each student learns through this to conduct informal interviews, to evaluate immediate impressions, to make objective summaries and statistical reports. In addition the student learns how to deal effectively with personnel in the clinic situation, with members of allied disciplines and with physicians, as a contact person for occupational therapy as well as in the role of therapist. We have long been eager to find the answers to a number of problems that we face each day and which we realize cannot be solved without substantiating data. Our hesitancy in doing something about it has stemmed not from inertia but from our awareness of our inability to carry out a research project successfully. We have been hampered by lack of research "know-how," as well as insufficient personnel and funds to support a study that would be valid. However, with the assurance of some assistance from a hospital research director in the near future to evaluate our purpose and methods, we have proceeded with a pilot study of the problem concerning the appropriateness of the arts and

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crafts media now being used in our department setting. At the outset we have recognized many variables and have predicted that many more would arise. This, then, has been another reason for attempting the pilot study before launching into research. We feel that by seeing the variables, corrections may be made which may eventually allow us to present an acceptable design for research.

Our investigation has been called a pilot study of patient selection of activity, and is more fully explained as "A Study of the Comparison of Patient Selection of Activities Prior to Hospitalization and in Treatment at the Cleveland Psychiatric Institute and Hospital."

The immediate purposes are: (1) to help determine the types of activities most frequently used by the newly admitted patient; (2) to clarify on what level the patient usually functions at the start of treatment; (3) to establish the similarities and or differences between the activities chosen in occupational therapy and those chosen by the patient prior to hospitalization; and (4) to aid in recognizing a patient's need to find an avenue for expression of his feelings.

Our hypothesis is: The level of activity selected by the acute emotionally ill patient is influenced to a greater extent by his psychopathology than by his pre-morbid interests and skills.

The anticipated variables are: (1) personality differences in interviewers; (2) differences in time lapse between date of referral, date of interviw, and date of first session resulting from inconsistent and sporadic number of referrals; (3) inconsistency of patient attendance during the observation period; (4) inconsistency of interview techniques due to ever-changing personnel (interpretation and practice); and (5) reliability of tools that are not as yet fully determined.

Our procedure has included initial interview, recording of that data, first observation, recording of that data, second observation, recording of that data, final interview, and evaluation and summary at the end of each student affiliation.

Changes made to date:

Because of the unevenness of the number of referrals received at one time, it became necessary for the interviewer to forgo the direct observation. This has resulted in a change of procedure. The interviewer now interviews or discusses the patient's response with the attending therapist to gain the necessary information.

We have had to revise the data sheets; with the change of procedure in observation it has been impossible to get some of the material we had planned on recording. The analysis sheets for observations have been changed three times. The interview sheet has been refined and simplified three times.

The interview form is in three sections. It includes information regarding the patient's prehospitalization occupation and leisure time activities, his anticipation for the future both while in the hospital and after returning to the community. This is in addition to the factual data pertinent to each patient.

The analysis of observation is in two sections. The first part covers the therapist's observations of the patient's response to activity and the second section is for the interviewer's followup of actual performance of the patient in comparison to his original statement.

The final interview consists of tabulation of the patient's verbal response to his occupational therapy experience.

Interviewing started May 11 and the trends that we now report are on our findings through September 11. Five people have been involved in the actual interviewing: three students and two supervisors. One hundred and sixty-four patients have participated, 92 of whom were female and 72 male.

From these 164 patients we have learned that apparently men become ill at the peak of their work record, since out of 72 male patients 30 were either in the professions or were doing highly skilled work. Twenty-one of these men had, at the beginning of their adult life, done unskilled work. The majority of both men and women are satisfied with their present jobs. The majority expect to return to their pre-hospitalization occupations. Six male and eight female employable persons were unemployed at the time of hospitalization.

Regarding spare time activities we have learned that the variety of interests is great, with 76 specific interests or activities designated. In addition, five men said they did nothing other than sleeping or relaxing for spare time activities. Two women and one man said that their spare time activity was drinking.

Nine women and eight men watched television as their only activity. One woman listened to the radio for her only spare time activity. Both men and women were concerned with activities that included the children. Women's activities, on the whole, were home centered while men's were primarily those that tended to take them out of the home. More women than men complained of lack of time for outside interests. More men than women wanted to do things with other people. Out of the 164 patients, 52 expressed no desire to develop a new interest or to continue with old ones, 98 out of a possible 112 would like to develop new interests and 72 of the 112 would like to continue with old interests. A total of 40

women and 34 men specified a preference for a job and an activity that involved doing something with their hands, 6 women and 9 men specified a preference for a job and an activity that primarily "used their brain," and 4 women and 4 men specified that they wanted a job and an activity that required both mental and physical involvement. More men than women (a ratio of 2 to 1) were interested in having a hospital job (industrial placement).

In occupational therapy the patients participated in 13 major arts and crafts activities which were broken down into 77 specific tasks. In the initial interview patients were questioned as to what activity they would like to perform. In actuality 33 of a possible 53 women followed through with their request and 25 of a possible 39 men followed through with their request. There were 25 women and 27 men who expressed no interest in doing anything. More women than men chose an activity that they were familiar with and men seemed to need more help from the therapist in making a choice of activity.

To prove our hypothesis we will, in addition to continuing with the present aspect of the study, expect to standardize the levels of activities used in occupational therapy and do a comparison of these activity levels with job classifications. We also expect to find what correlation there may be between activities chosen prior to and during hospitalization; what correlation there may be between cultural background and activity chosen; and what correlation there may be between activity level and educational background. We expect to find the possible influence of previous hospitalizations, the possible influence exerted by other patients and, finally, evaluate the patient's interpretation of occupational therapy.

THE MINNESOTA FOLLOW-UP STUDY

VIOLET B. FRY, O.T.R.*

The Minnesota Follow-up Study (MFS) is a research-demonstration project financed by the National Institute of Mental Health. Because the grant was made to the State of Minnesota, our state department of public welfare's medical division is responsible for administering the study.

Essentially, we are concerned with pre-discharge planning and community follow-up of psychiatric patients discharged from the Moose Lake State Hospital and returning to St. Louis County. Geographically speaking, this is the largest county in the state and approximately one half of the patients at Moose Lake are committed from there. Also, the population is both urban and rural and presents a broad cross section of nationalities, cultures and industrial pursuits.

Using a direct quote from the project design as a definition of our purpose, our assignment is: "To determine whether a period of special planning for the state mental hospital patient's discharge, begun at the time of his admission, will significantly affect the quality and duration of his post-discharge adjustment. Secondly, to determine whether an intensive effort directed at mobilizing existing community treatment, counseling, casework, recreational, job placement and other rehabilitation facilities for use by the released mental hospital patient will significantly affect the quality and duration of his post-discharge adjustment. Thirdly, to determine the degree to which pre-discharge planning in combination with the mobilization of existing community rehabilitation services will affect the quality and duration of the state hospital patient's post-discharge adjustment."

Basically then we are concerned with two factors: "pre-discharge" planning with services and patient manipulations that may be more than the present routine, secondly, "follow-up" in the community that will make more effective use of existing facilities.

The research staff is composed of two teams. Team one centers its work at Moose Lake State Hospital. Currently there is a psychiatric social worker, occupational therapist, secretary and a psychiatric nurse who divides her time between the two teams. Plans call for a psychologist on this team too.

Team two, working at the community level, includes the psychologist, social worker, occupational therapist, nurse and two secretaries. Supervising is the project director.

At present two registered occupational therapists (civil service classification: project rehabilitation therapist) are actively engaged in the project. Let us consider first the unique position at the hospital level. We have a therapist employed within a hospital setting in no way active in the clinical program but rather functioning as an observer. The attending physician alerts MFS that a patient in the hospital experimental group has reached a point in his convalescence when

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pre-discharge planning may begin. The present rehabilitation therapist as well as the study's psychiatric social worker and the psychiatric nurse conducts an initial interview. The therapist talks with the patient about activities in recreation, employment, religion, handcrafts, reading and use of leisure time. Hospital personnel are contacted and hospital records are consulted to verify or add to knowledge gained.

This information is presented at an assessment staff meeting at which time all disciplines participate in planning for the remainder of the patient's hospitalization. Where indicated, changes are made in his industrial, recreational or occupational therapy assignment to observe reaction to change and increased stress. Needless to say, all such maneuvers are done with the consent and approval of the medical staff of the hospital. Also, accurate progress records must be kept and reported back to the research staff for coordination.

As a departure from routine hospital activity, the Minnesota Follow-up Study has instituted a series of meetings known as the DO group (discharge orientation) with the therapist serving as the coordinator. Covering a vast field of interest to the patient, discussions include post-discharge problems, introduction to community resources and key agencies, and the importance of planning work, play, rest and religious activities. Again, the therapist records her observations as to the patient's ability to participate in a group and ability to interact with others. This group meeting also is a good tool for continuing contact with the patient. Our present feeling is that such contacts are effective for pre-discharge planning but do not serve any special function for research.

Sometimes those who have been hospitalized for several years must be oriented to this changing world. Again the therapist schedules any community visits deemed essential to effective planning for this group.

Let us look at the activities of the therapist working with the community team. In the preliminary phases of this project we made a survey of resource agencies and persons available in St. Louis County. This survey is maintained by the rehabilitation therapist and serves all disciplines.

With those patients who are part of the experimental category, the community team proceeds with the follow-through on plans. Using the recommendations of her hospital counterpart, the therapist guides the returnee in finding his niche in that area that may prove best for him. This may be found in creative use of leisure time, recreation, adult education, religious activities or social gatherings. The therapist does not do the actual teaching but utilizes any pertinent community resource. The plan is to use a corps of volunteers working under our supervision to carry through for those persons who cannot be motivated to self-help. In those cases requiring continued therapy, we make the recommendation to the patient's physician and he fills in the prescription with a referral to the Duluth Rehabilitation Center or any other organized clinic offering such service.

What happens to the hospital control patient who becomes part of the community experiment? Employing the same techniques that are used at the hospital, the therapist conducts an initial interview to evaluate the dischargee's use of time. With all disciplines present, an assessment staff meeting is held and preliminary ideas and suggestions are developed to assist in planning with the client. Proceeding as before, we implement the plans and guide the follow-up.

In some instances the therapist may be assigned primary responsibility for a given case. When this is done, she is the main counselor for the client but is expected to use her knowledge and skill and to refer to other workers those problems that rightly belong to social service, psychology or nursing.

And where does research come into the picture? A diligent search soon made us aware of a disturbing fact. No one had developed any measuring sticks for us to utilize. Of necessity we needed instruments that could be coded for pertinent information. Since such activity was not a part of our training, the present therapists have been grateful to our clinical psychologist, Dr. Robert J. Wolff, for his guidance and encouragement. First to be developed was a "Rehabilitation Rating Scale." This has been put into use at Moose Lake recently and hospital personnel are cooperating by scoring these. Interestingly enough, the present form is a revision of three separate scales written by Inez Huntting when she was a member of our staff. Ratings are made as to "Response to Work" and "Response to People" (socialization). The rater's evaluation of a particular patient will become part of the base line information that is being gathered for all St. Louis County patients. This scale consists of material supplied by occupational therapists and as a by-product of our study may well become a means of measuring a patient's progress in an on-going therapy program.

In order to avoid confusion in the collecting of material to be presented to the assessment staff, the therapists have been developing a coded interview schedule. This will provide information as to pre-morbid interests and activities, participation in the hospital program and, finally, participation within the community life upon discharge. Research-wise this may help support the

sub-hypotheses that a better and more enduring post-hospital adjustment will be possible for a patient who:

1. Carries hobbies and interests developed in the hospital into his post-hospital life
2. Has a wide range of social activities, club memberships, hobbies and other evidences of good socialization prior to hospitalization
3. Was a competent working patient in the hospital prior to release
4. Had high ratings on hospital administered behavior rating scales
5. Had a strong formal religious affiliation

And then we come to the inevitable and ever-present progress notes. Because we are engaged in a research project, we must keep periodic checks on all experimental and control patients both in and out of the hospital. Again working as a single unit, we are bringing into being a coded recording device. A common code is being used for the areas to be checked, i.e., leisure time and occupational therapy, recreation and recreational therapy, employment and industrial therapy.

As you will note, one is a community term and the other is in hospital terminology. The two project therapists use separate codes to denote hospital or community and each has her own report sheet. Our aim in the development of the last two research forms is to give a continuous flow of information without a cumbersome load of paper work. Hence the coordinated effort. Also we feel this may provide an answer to how effective our hospital programs are in giving the patient something to carry over into his daily life.

While duties of the two therapists are similar, each operates in a different setting. The hospital setting makes all experimental patients readily accessible. Since St. Louis County covers an area of 6,611 square miles it sometimes becomes more difficult to contact a patient once he is back in the community. Again our community agencies have proved valuable to us by coordinating our plans.

We are aware that this study is a departure from our usual occupational therapy activities, but we also foresee a broad field of expansion for our profession. If we are to continue to grow and to take the initiative in promoting our contribution to medicine and society we must step forward confidently and positively to prove ourselves capable and worthy to take our place in the field of research. In our case we have gone beyond the clinic wall and rightfully so. We have been given the challenge and we are striving to make occupational therapy a concrete part of the research team.

THE PROBLEM OF PRESENTING AND REINFORCING REALITY

HAROLD M. VISOTSKY, M.D.*

In discussing the problem and necessity of presenting reality to the patient within the treatment program, we are confronted with the many variables concerning reality under these circumstances. What constitutes reality to the patient? What are the patient's defenses against an uncompromising reality? What are the consequences of poor defenses in a patient? What can we do to revamp and rework poor or neurotic defenses in a patient?

In dealing with patients who are reacting to an illness we must be aware of the changes, both external and internal, and particularly the emotional concomitants of any severe or disabling illness.

I could not possibly begin to tell you about the techniques of presenting reality to a patient without first going into the vast field of emotional reaction to disability and chronic illness. "A physical defect has a unique personal and often deep unconscious significance for the disabled person for physique is one of the principal raw ingredients of the personality. It also has some social significance for physique is one of the grounds upon which class and class distinctions are made."[1]

Various studies show that the most commonly used nicknames by children refer to physique such as: "four-eyes," "fatso," "red," "shortie," "freckles," and you are all aware that plays and films have long utilized the physical attributes of individuals for comedy effect. Studies have been made which have pointed out that if normal variations in physique, such as being strong or weak, tall or short, handsome or ugly, are important factors in personality formation then clearly the pathological variations known as physical disability are likely to be even more potent. The physically disabled child, at an early age, receives an unusual amount of attention and help and thus is the recipient of social status and self-esteem. However, as he becomes older, his

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reaction to his disability changes: he is more expensive in terms of time and money; the parents may reject the child in terms of resentment or guilt. This rejection may be transferred to the child who, in turn, resents the parents but, being dependent upon them, is forced to suppress his blame which then produces self-hostility, guilt and anxiety. On the other hand the parents, either from genuine sympathy or guilt reactions, may tend to over-protect the child with equally hostile results. In either instance the child's ego and social status needs are frustrated and, as the child grows into adulthood, he becomes categorized as a member of a minority group and, in many instances, is socially ostracized and rejected by physically normal persons. He is discriminated against in employment even for jobs which he is physically able to perform.

The handicapped person is a marginal person physically, socially and economically. Many avenues of normal relationship are blocked to him because of his actual disability or his attitude toward his disability. Social pressure can produce more frustration and conflict. Thus the physically handicapped individual may bear the added burden of social rejection and emotional conflict.

We also know there is an "X" factor in human nature, which some people call motivation. In patients who are remarkably or strongly motivated to get better we see frequent improvement despite severe physical handicap, whereas mildly disabled patients, who regard themselves as hopeless individuals, may remain just that to the end of their days. The logical corollary of this general clinical observation has been to devise means to increase the motivation of these patients.

"The problem of motivation is an extremely complicated one in which technical aspects constitute the psychological approach to rehabilitation. It is in this area that the psychiatrist, with his research and insight into the deep-lying irrational and unconscious forces that determine the direction of intensity and motivation, can make specific contribution to the rehabilitation of the patient."[2]

I think all of us have heard, and even accepted, the concept of "body image." One of the most fascinating paradoxes of human condition is that the human body which unites us as a biological species gives rise in each of us on a psychological level to a body image which is specific for that individual. The body image may be influenced by the individual's occupation or beauty or shapeliness of particular parts of the body. To a certain extent the body image is culturally determined by the intimate association of the body image wth a person's sense of his own worth and his place among other people. It goes even deeper than this. When we talk of the irrational aspects of the body image, we might gain a greater insight into the exaggerated reactions in some cases that appear to us as inappropriate emotional reactions, particularly if the patient has suffered some injury or loss of a part of the body. We all know patients who seem to react with excessive fear, apprehension or depression to relatively mild injuries, while seriously disabled patients may act with a calm, strange indifference. Others puzzle us by their seemingly inappropriate reactions of guilt or shame. Some show varying degrees of childish, immature behavior. It is helpful, in regulating our own emotional reactions and attitude toward such patients, to bear in mind that the adult patient who has suffered sudden disablement has two kinds of adjustment to make. He must adjust himself to the realistic limitations and adaptations imposed by the disability. Secondly he is suddenly called upon to modify his body image—his conception of himself, his relations to people, his work—in accordance with the nature and the extent of the disability. The psychological adjustment may have implications to the patient that are far more crippling to the total functioning of the person than the physical disability itself. In the process of revising his body image, the patient may experience the reawakening of long-forgotten conflicts and associations with emotionally painful events and feelings of the past, the result being that he falls back on immature patterns of behavior characteristic of his childhood. This regression, as we call it, is usually a temporary phase of the psychological adjustment to any severe and sudden disablement.

The rehabilitation team can help the patient work through this difficult period by accepting the patient's childish or irrational behavior as a natural phase of adjustment to his disability, much as one accepts the behavior of a child. This does not mean that one should treat the patient as a child, or adopt a patronizing or condescending attitude toward him. It is quite possible to accept regressed behavior as a part of the present reality to the patient and, at the same time, identify oneself with the more mature aspects of his personality which must be supported.

Those who neither accept their handicap nor yield to it raise special problems for those of us working in rehabilitation. In such cases the educational approach is sometimes most promising, as the patient must be told unequivocally of the nature and extent of his disability. If the patient's queries concerning his disabilities are met with vague or evasive replies he may develop a false hope of eventual recovery. As long as this hope is alive he can never reach the stage of active acceptance which is his only hope so far as rehabilitation is concerned.

When the denial stage can no longer handle

the forces of anxiety and stress, the patient begins on some level — conscious, preconscious or unconscious — to recognize the essence of the reality of the situation. That is, that he is going to be disabled or is disabled; that changes are being made in his body image which he must accept, at least in part; that he must be able to handle the changes in his family's attitude toward him, society's attitude toward him and his attitude toward society, his family and plans for the future. All these must now be adjusted in the face of the disability and it is at this point that the patient usually enters the second stage, that of depression.

In the acute stage of illness there is a sudden and massive constriction of physical and psychological life. In other words, in the patient's struggle to live, all other considerations are overshadowed. It is only when life is not immediately threatened that the individual becomes more aware of his changed relationship to himself and to his environment. If this awarenes brings the realization that a state of chronic illness or disability lies ahead, then the mourning reaction to what has been lost envelops the individual. There are several aspects to this mourning reaction. Initially there is the emotional reaction to the catastrophy that has overaken the individual. This may express itself in overt emotional despair or an acute feeling of inadequacy, hopelessness, defeat or numbness that is emotional withdrawal. The mourning may be perpetuated by one or more of the following facts. The change in the physical status of the patient resulting from the acute illness tends to emphasize what has been lost. The capabilities which have not been impaired tend to be forgotten at the peak of mourning. Moreover, preoccupation with the loss leads to a characteristic distortion in which the loss is perceived as much greater than it may later prove to be. This emphasis on the loss aspect is the core of the mourning reaction. An important motivational factor is a need to cling to the past as long as the psychological past can be actively alive. The memory of abilities which were available then can be cherished now and the sense of loss can be deferred. The mourning is somehow nourished and sustained by this wish for the past, the wish to be as before, and to maintain a concept of the body image unaltered. The mourning reaction itself produces a hopelessness which sees no satisfaction in the present, and which makes impossible a gradual yielding of the past.

A certain amount of mourning for loss is to be expected. It would therefore be therapeutically unsound to attempt to shorten too rapidly this mourning period. Artfully contrived methods to divert the patient's attention from himself may lead to the feeling that people do not understand, that they do not appreciate the patient's loss. This is especially apt to be the consequence of a premature reassurance to the patient about the future, if the reassurer himself is intact in the area of the patient's loss. There is also he possibility that if distraction techniques work too well, when distraction is no longer effective full realization of the loss may return in an exaggeration of mourning.

Many of us have seen patients who, through their attitude and through their inability to ask appropriate questions of the staff, indicate that they do not want to know the dimensions of the disability. It is as if they were playing ostrich. There comes a time when the patient should change, should make plans to participate in a rehabilitation program, when reality must be presented to him. It is then that with tact and respect he be apprised of the severity of his illness. Timing is very important. When the period of constriction is over and there has been a suitable amount of mourning, we must begin to work with the patient in terms of the present reality. We must help him accept this reality and offer him the services of the rehabilitation team in formulating mechanisms to adapt to the situation.

If a patient should not show a mourning reaction to a severe disability or chronic illness, this would be a serious symptom and would require careful consideration by the team and its psychiatric consultant. Those of us working in psychiatry know that there is no growth and no treatment in the absence of anxiety. A person cannot be treated who is not anxious about a specific problem. It is this anxiety, this discomfort which produces the field in which growth and therapy can be provided. It is in this period, following the gradual acceptance of disability, that the beginning of the rehabilitation process is instituted.

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ASSISTIVE DEVICES FOR ACTIVITIES OF DAILY LIVING

HELEN L. HOPKINS, M.A., O.T.R.*

Since the occupational therapist usually trains patients in the use of devices and has, along with medical background, a knowledge of tools, materials and sources of supply, he is the logical person to provide devices for the patients. Thus it is up to the occupational therapist to orient the doctor, if he does not already know, as to the factors to be considered when prescribing a device, so that the best possible answer may be found for each patient. This does not mean that the therapist tells the doctor what to prescribe, but after analyzing the situation, a solution may be suggested to the doctor pointing out the reasons for the selection. This is sometimes a controversial point for not all occupational therapists have the knowledge of materials and sources of supply that a specialist in the field would have.

However, if the principles involved in selection of devices are known both by the therapist and the doctor, a functionally adequate device can be provided either through commercial sources or by fabrication by the experienced therapist. These principles have been discussed and written about frequently so it is not my purpose to go into these in detail, but rather to review them and then demonstrate them through their application to the use of specific devices for one activity—writing—for patients having various types of disability.

There are four aspects which must be considered in analyzing the problem in order to provide for optimum selection of a device. These are physical abilities or disabilities of the patient, psychological ability to accept devices, mechanical aspects of the device and financial status of the patient.

In evaluating the first aspect, that of the physical ability of the patient, one factor that must be considered is the physical status of the patient himself. Here the need for devices usually falls into one of three classifications: those needed because of lack of power or strength, those needed because of lack of range of motion and those needed because of incoordination.

The second factor concerning the physical ability of the patient is the analysis of motion required to perform the activity desired in reaching the goal of the patient. Activity analysis should be a basic procedure for the therapist. As an example, each of us normally writes using a certain pattern. If the method normally used is no longer feasible due to lack of finger motion, an alternate method may be utilized through the use of a holding device, and may prove to be adequate.

The second aspect that must be considered for selection of a device is that of the psychological ability of the patient to accept a device. This is determined by the age of the patient, the length of time he has been disabled, the extent of his disability, the duration for which the device will be needed, and the cosmetic appearance and cultural acceptance of the device. The last factor is often the primary reason for rejection of a device.

The cosmetic appearance is extremely important, for patients do not want to feel that they are different. They will accept more readily those devices which are either inconspicuous because of color or placement, or are devices which in this gadget age might be used by the normal person. Of course this is not always possible, so here is where the cultural acceptance comes in. If a patient is from a culture where any type of disability is frowned upon or catered to, he is not likely to accept a device easily, e.g., if a child has a doting mother, she will often not allow him to do those things for himself which he could do with devices because she enjoys waiting on him. On the other hand, if it is essential for the patient to be independent in his home environment, he will often accept devices which make him functionally adequate through they are not as acceptable cosmetically.

The third aspect to be considered for device selection is that of mechanical properties of the device itself. This can be important from the standpoint of acceptance of the device and practical considerations. The factors involved here include the weight of the device, its durability or strength and its cleanliness. These factors will be important especially if this is to be a permanent or semi-permanent device. Simplicity of design and ease of adjustment or adaptation are very important, for the functional value should not be outweighed by the nuisance value of the device.

The last aspect in the selection of a device is that of the financial status of the patient. This may seem relatively unimportant but may determine whether a device is prescribed or not and which one is selected. It is here that the occu-

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pational therapist must use ingenuity in trying to devise a satisfactory but inexpensive device. This has been and is being done constantly by therapists throughout the world. Examples: button hook from paper clip, dressing stick from a dress hanger hook and a dowel. In addition to these inexpensive devices which a therapist can fabricate, there are fortunately some rather inexpensive devices available commercially. Examples: Fascole Corporation, J. A. Preston, Button King Corporation.

From the purely practical standpoint it is often less expensive to buy the device than to make it, for if the cost of the therapist's time is included in the cost of the article, it would be considerably more expensive than buying it from one of these companies that can have them mass-produced. A leather utensil holder costs $1.00 to buy, but would take a therapist at least a half hour to construct and his time is certainly worth more than that.

Usually when financial status is cited, the only consideration is lack of funds, but many times the need for devices can be minimized when a patient has a great deal of money. A certain patient could be completely independent in his dressing and self-care activities through the use of several simple devices—such as a button hook, long handled shoe horn and elastic shoe laces—but has no interest or desire to learn to use these for he has always had a valet to dress him, and thus feels no need to learn these things. In another instance, a patient could have been independent in an electric wheechair, but because her home was in the West Indies where labor was cheap, she could easily get someone to push her where she wanted to go, this was preferable to her.

I should like to demonstrate these principles for selection of a device by considering a group of sample devices used for writing. The first type of writing device is one which requires only a built-up handle for lack of grasp due either to weakness or limitation of motion. The simplest of these is the rubber ball or wooden built-up pencil. It has been our experience that the square holder often works better because the fingers stay more readily on the flat surfaces. There is usually no difficulty in getting the patient to accept the use of this type of device because it is relatively simple, does not look unusual, is inexpensive and frequently may be discarded for regular pencils.

Other types of built-up pencils which may be used more for the incoordinate patient would be: peg writing device, clothes pin writing device or button king writing device. These devices have pegs or small dowels around which the patient can wrap his fingers and thus give him more control, yet are quite simple and inconspicuous.

A new materital which can be used to build up pencils, either for the incoordinate patient or for lack of grasp, is Cold Set, a plastic material consisting of a liquid to which a powder is added in a proportion of 2 or 3 parts of powder to 1 part of liquid. When it is the consistency of thick putty, it is rolled into a ball and placed around the pencil or utensil which is to be built up. The patient, whose hand is coated with soap (as a separator), grasps the Cold Set covered object in the desired position, leaving his finger prints in the plastic and then immediately releasing his grasp and allowing the plastic to harden. This type of device has the advantage of being quite acceptable cosmetically and is easily kept clean; but if weight is a problem, this might not be the answer for it is quite heavy.

This material can be used for casts or splints by rolling the material like pie dough and cutting to shape with scissors. It is then shaped on the patient's hand or arm which has been coated with soap. When hard it is quite brittle and thus may not be satisfactory if the splint is to have rough treatment. In addition, once this material is hard it cannot be changed or adjusted.

For built-up handles Cold Set is a good material but rather expensive. A kit of one pint of liquid and one quart of powder costs approximately $8.00. This kit would make about 12 to 15 built-up handles. A simpler method was brought to my attention by a Yugoslavian who has used this method in his country and says it is frequently used throughout Europe. Using a dampened piece of bread, a doughball can be made which can be used for building up a handle and the patient can grasp it in a manner similar to that used with the Cold Set. The bread does not mold, but takes several days to harden. It may then be shellacked to keep it clean and non-porous. One of the disadvantages of the bread is that it cracks as it hardens and therefore is not as smooth nor cosmetically acceptable as the Cold Set.

If more assistance is needed than that provided by a built-up pencil, finger rings may be made from strips of metal to fit the thumb and two fingers of the patient who has little grasp due to lack of power. A simple method of testing the value of this type of device is through the use of three notebook rings fastened together with a rubber band through which a pencil can be inserted, so that the fingers are held on the pencil in the three-jaw-chuck position. In most cases this would only be a testing device and a more permanent one would have to be made to fit more closely; but in some cases, if it is to be a temporary aid it may be all that is necessary. This type of device would not be satisfactory

when there is loss of sensation for there may be pressure caused by the rings. In the case of a quadriplegic patient, if finger rings were to be used, they should be fitted carefully and perhaps should be covered with foam rubber or Plastisol.

Usually finger rings alone are not sufficient for the needs of a quadriplegic patient, however, for the rings slide off unless there is another point of stabilization as provided by a pencil holder to stabilize the pencil at the palmar surface of the hand in a leather utensil holder. This is often satisfactory functionally for the quadriplegic or for the patient with complete loss of hand motion, but the patient often cannot put this device on himself and therefore it is inadequate. For this reason the Fiberglass cuff was developed with a pencil clip on it to stabilize the pencil. The cuff fits over the back of the hand and fingers like a glove, holding the thumb and fingers on the pencil in the three-jaw-chuck position. Thus the patient can slide the device on and off himself which makes him more nearly independent in his writing. By the addition of a telephone dialer, the patient could also use the Fiberglass cuff for activities such as dialing the phone, typing and using the calculator. From the standpoint of vocational goals this type of device could make even the quadriplegic patient more adequate in an office job. For those who have Celastic or Airecast available, a very satisfactory writing cuff can be made which will work as well as Fiberglass, but will have some disadvantages cosmetically. The appearance may be improved by the use of flesh-colored paint, however it is somewhat heavier and not as strong.

To make the cuff, a plaster cast of the patient's hand must first be made, then a plaster mold is made and the Fiberglass or Celastic is formed over the mold. This process is usually necessary even with the Celastic because it has a tendency to shrink as it dries and therefore would not fit if it were molded directly over the patient's hand and then allowed to dry off the hand.

This presentation illustrated only a small portion of the possibilities in this field, for new ideas are constantly being developed. I have only analyzed devices for one activity. However analyses of several other activities, by Miss Muriel Zimmerman, O.T.R., have been published in the *American Journal of Occupational Therapy* and the reprint is available free of charge from the Institute of Physical Medicine and Rehabilitation in New York.

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Calendar of Events

August 28-September 2, 1960

Eighth world congress of the International Society for the Welfare of Cripples, Waldorf-Astoria Hotel, New York City.

September 3, 1960

The first international congress of Histochemistry and Cytochemistry, Paris, France.

October 13-15, 1960

Mississippi Valley Conference on Tuberculosis, Schroeder Hotel, Milwaukee, Wisconsin.

November 13-17, 1960

Conference of the American Occupational Therapy Association, Statler Hilton Hotel, Los Angeles, California.

August 30-September 5, 1961

Sixth international congress on mental health, Sorbonne, Paris, France, under auspices of the World Federation for Mental Health.

MILIEU THERAPY

JOSEPH NOSHPITZ, M.D.*

The flow of clinical practice seems always to move away from the patient's natural setting and everyday adjustment. Patients are forever being taken into offices, examining rooms, treatment rooms, playrooms, and therapeutic shops where they are to receive their moment of study, or therapy before being restored to their home or ward. The more intensively and carefully we have trained our various staff specialists, and the more precisely do they learn to use these various rooms and the equipment within them, then the less likely are they to abandon all this in order to become involved in the ongoing business of the patient's day to day life.

The way we work for the most part seems to hinge on the premise that the patient can use the structure of offices and schedules and shops in a manner that will be therapeutic for him. This seems obvious enough on the face of it, but really raises crucial questions in terms of formulating an approach. Does an hour of sublimated work at 3:00 p.m. no matter how skillfully supervised, have any bearing on the emotional upset of 10:00 a.m. the next morning? How do we relate the particular bits of what we do in this office or that, to the whole concept of improvement, in particular what right have we to connect these moments of activity with patients, to the way in which very weak, sick egos achieve significant alterations. Freud himself felt that so trenchant a tool as psychoanalysis must fail with a large group of sick people who exhibited among other symptoms marked ego weakness, and while this opinion is in question in some quarters, there is certainly reason to feel that no piecemeal approach, however skillful, will profoundly affect a very large group of the most seriously ill patients.

As a result we have seen a concept of milieu treatment come into being in recent years, but a sense of clarity and sharp edged definitive practice have not yet come to be associated with the term. Indeed one wonders sometimes whether statements about milieu are not descriptions of good intentions, or points of view, as much as they are descriptions of how to treat patients. The notions of moral treatment advanced by Drs. Ray and Kirkbride or even by the Tukes many years ago is not too different from the concept of milieu treatment, i.e. an hygienic, emotionally sound environment, respecting the patient's feelings, supplying him with pleasant and constructive activities. If we go at it more actively and call it total push, or if we emphasize our response to the patient's feelings and call it attitude therapy, we don't have much more to show for it in terms of defining a discipline of practice then did our historical predecessors.

And so the office and shop continue to be the areas of greatest security for our several groups, the places where we can work with maximum precision and in the most antiseptic way—not always with a clear conscience, perhaps, after all so much happens in a patient's life, but certainly with the safest feeling.

In developing the program for disturbed children at NIH, it was clear from the outset that such youngsters would not be good candidates for any of the usual types of therapy. They were selected for their aggressiveness, their explosiveness, their impulsiveness, and their negativism. They were disturbed in every significant area. For the most part they couldn't use school effectively, and they were unpredictable in the extreme, so far as projects went. Much of what they touched they mutilated or destroyed, not excluding each other to some extent.

It was deemed necessary to meet these youngsters on a much broader base than that of the scheduled day in the shop, school, and therapy periods; these structural elements were necessary and good, but they were insufficient. The youngsters' egos were sick all the time. and the therapy had to be there all the time. Planning for them was not a matter of schedule, it was a matter of programming in depth so that such problems as could be anticipated could be headed off, and in the face of unexpected difficulties there would be alternative plans and the necessary materials always available. The control structure for the impulsive blow-up or uncontrollable act was in the background of each plan, and over and above all this, a consistent and effective set of tactics had to be developed to bring to bear on the many difficult situations that would arise.

It was with this in mind that Dr. Redl developed the techniques which have come to be called the marginal or life space interview. Here was a tool for milieu therapy par excellence, a style of approach to each difficult and trying situation with a child, that exploited much that we have learned from decades of psychotherapeutic interviewing, and added to this the primary focus on the here and now in the patient's behavior. For the life space interviewing took place in the here and now; it was focussed on the immediate act, or it summarized the last few times this act had occurred—it often took place in the patient's

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own room or at the site of the difficulty, and it was an active attempt to work with the ego problems of the particular youngster at a point where susceptibility to being worked with was often at its height.

This style of work was one example of a larger philosophy of bringing the sharp edge of treatment out into the life of the patient as he lived it, rather than confining it to the specialty room. This "life" was in itself a synthetic affair, built up on three major premises. The first was in answer to this question: Aside from all questions of pathology, what does the youngster need for ego maturation? And in the course of meeting these needs, a world of projects and activities emerges quite naturally. For example, a most important ego building technique is school. School for younger children is far more than an area for acquiring new knowledge, it is a site of major ego growth. Whole universes of latent capacity can be awakened and developed by this instrumentality; and the omission of adequate schooling means the withering and atrophy of important areas of ego function. Similarly, mastery of certain physical skills as channels of expression and areas of pre-vocational preparation requires suitable opportunity for training and experience. This ego building area then would be one major group of needs which the milieu might undertake to meet, both in the day to day living and in the specialized treatment area.

The second premise on which the milieu is built is that the child has pleasure needs—the need to enjoy himself in his interactions with other people, and to have satisfying and pleasant experiences that have no other specific function than to make life more pleasant and more wholesome. One might well make a point of the similarity between this issue and the immediately preceding one; in fact however, the way programming is regarded by the staff is probably not identical in each instance.

The third premise is of course the obvious, the child is sick, he needs treatment, how can we build that part of our work into his life?

In any case, in bringing the focus of our attention *into the child's* life rather than tangent to it, we see each of the therapeutic modalities undergoing a meaningful shift. Psychotherapeutic experiences occur in the course of the life space interview; music becomes focussed around group dancing that may happen to take place spontaneously at any time on the ward or on the chance playing around with the ward piano. This youngster or that or the group may engage in projects anywhere—in the wood shop, the OT playroom, the child's sleeping room, the day room, etc., activity specialists of every kind function on the ward rather than out of their particular home offices, and the style of life becomes treatment in the here and now rather than in the there and then.

This cannot be achieved without considerable sacrifice. The force of gravity always drives specialists into their private and individualized hand-tailored environment. And within limits this is a desirable state of affairs, it is important for each specialist group to retain its professional identity. But the realization of that identity must now take place as a particular way of functioning within the patient's life space, not on the particular functioning of the patient within the specialist's life space—and so the threat to identity is a real and vital issue.

ACTIVITY PROGRAMMING FOR THE AGGRESSIVE CHILD

EDITH MAEDA, O.T.R.*

When the child program was set up at the National Institute of Mental Health at Bethesda, Maryland, the director was willing to see what occupational therapy could contribute to the project. The assistant administrator, a group worker, had developed a ward program along camp lines which required that programming be used as a full-fledged therapeutic tool, and a major area for research was to learn how to do this more and more effectively. My problem was to find out how an occupational therapist could fit into this set-up. The director had instituted the practice of having each new child-care staff member act as a counselor in order to learn to work with the children and the staff through an entire working day. Therefore I started my work as a basic child-care worker and rotated through the different shifts just as a counselor would do. I learned what that role entailed, how the children responded at various times and places, what activities meant to both staff and patients and how the youngster handled the various demands we made on them. This turned out to be an ideal way to break into the ongoing pattern of ward life.

It is no easy job to walk into a highly complex operation, even if one agrees wholeheartedly with the current philosophy of management; it is harder still if one's training has not specifically covered the tasks at hand. This chance to have an identity which was already clear cut and understood by both staff and patients offered me the opportunity to float, to learn and to observe with relative comfort even though my activities were still a far cry from occupational therapy as I knew it.

After two months of being a counselor, the assistant administrator and I formed a collaboration whose mission was the structure and scheduling for the children's day. I began to work closely with the various members of the counselor team, helping them pre-plan their activities. In addition I took over as my own task the direction of certain activities with a group of the children. I conducted a weekly council meeting during which six boys and I sat at a table together. I listened to their ideas, complaints and needs and saw to it that their suggestions got translated into an activity program. A typical council meeting had to have some format and order or nothing would have been accomplished. Individual suggestions opened the meeting and those children who were ready were recognized. The special announcements were kept for the end of the meeting so as to add to the expectation level as well as to give the meeting a natural closure. This gave a leverage by which the meeting could go on with as little interruption as possible.

In addition I met informally and frequently with the counselors who lived with the children night and day. Their needs had to be met too and the way this was done or not done had an enormous bearing on the effectiveness of the program.

For example, the evening team found supper time and the immediate post-meal time very hectic. Watching the staff trying to deal with stragglers as well as those who might have to be escorted out of the dining room proved to be too much for those children who were in good shape. At the same time, the counselors themselves were not getting a decent meal to last out the rest of the evening. To cope with this, program tactics were revised. It was decided to have a dayroom game period after supper. As soon as a child left the table there was an organized game awaiting him. Since the dayroom was next to the dining room, the counselors could eat their supper and be in view of the children throughout the game. The adults helped the practice along by playing up the forthcoming game at supper time and later by supervising it from a distance. Games like hide 'n seek, yard tag, towel tag and hop skotch were a few the children never seemed to tire of and could be carried on with moderate safety with a minimum of adult activity.

As a result of such work, the counselors found that I had something to offer them. By setting up structures within the program, planning activities at strategic times, offering them tools by which they could support the child as well as allowing themselves room to handle behavior, their work became more effective.

In return they were able to give me support. If I or any other member of the team was responsible for a given activity, we were not expected to handle the inevitable boisterous child who might be trying to sabotage the whole activity. Some less involved team member would step in and remove the child. Sometimes I worked on the periphery. In this way each team member was contributing to the total effect, which had terrific influence on staff morale.

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In doing all this, we worked with a certain philosophy which we understood and agreed with. In general, as we saw it, programs began with the child and his needs. We assumed that whether his needs were developmental, social, emotional or physical, they would be expressed in many ways. In our particular type of child, it was not always easy to recognize the nature of his need. Explosive behavior would be the final common path of response to a wide variety of stimuli, and would demand our immediate attention. Often it was only after the storm had been weathered that some exchange with the child could reveal what it had been about. Sometimes the child could not tell us and it became a matter of tactics to handle the disturbance with what skill we could.

The struggle and the antiseptic removal usually came before the actual recognition of the need. With our children this was the prime management problem. The stimuli seemed to be ever-present and the impulsiveness was discharged in large doses. It therefore became important to find tactics that would minimize the occurrence of these blow-ups and it was for this in particular that a program was vital.

It seems useful to divide the elements in our approach to the program and activities into three categories: time, space and content. Each of these was important for working out a plan to fit the needs of these children and each will be discussed as a separate entity, although in fact they all had to be weighed carefully in each instance before deciding where to go and what to do.

Timing meant the art of selecting when we would exploit life situations and when we redirected the impact of tension-building situations into a natural physical outlet. Thus, post-school periods each morning involved a movement out of the ward into a greater expanse where the youngster could run, jump, leap and literally work off the dammed-up tension he had accumulated in making the difficult adaptation to school.

The second category, space, was important too. To these children, defined areas offered control and meant in some instances the difference between secure containment and panic. Their life space was therefore carefully measured out and assigned. The living area was the first and smallest increment of space they could use. It contained familiar surroundings such as bedrooms, dining area, a kitchen, a living room and a large play area. The next degree of spacial expansion outside of their immediate living space was off the ward in an adjoining corridor. There the youngsters attended school and had access to their own shop. These were still locked areas where a certain amount of security prevailed.

Still further out from their home orbit lay other hospital facilities such as a library, a gym, an outdoor enclosure and an occupational therapy area where a playroom and a music room were shared with other patient groups. Furthest out of all was the community. The movement from inner space to outer space was utilized to its fullest. This was dependent on timing in most dramatic ways. We learned early that if a separation was impending, it was desirable to have more structure within the confines of the life space. At such a time, e. g., before a long visit home, any movement outside the containment provided by the unit led to contagious "testing-out" which often resulted in elopements. The anticipated separation was re-enacted more safely in fantasy-type play on the unit where emotional release could be sought in a highly structured type of activity and routine.

Special places had special meanings and particular jobs to do. For example the patient library was one of the more regular stops. This was actually used as a link to the community. At one stage in our work a group of children moved out of the closed ward into an open cottage setting. Before they did so, we made arrangements to visit the local community library and explore its structure. In many ways it was similar to our own library, except for its larger facilities. The children applied for library cards and experienced the first move into the community after two or three years in the hospital. When these children eventually enrolled in public schools, they were once again exposed to the now familiar experience, this time with the school library. Two of our children were able to find a ready-made and gratifying role when they were promptly selected as librarians in their respective classes. This latter point is presented to illustrate the importance of exploiting hospital space to provide the links to the community to which all these children eventually return.

On weekends we planned group outings which got us out of the closed setting with fair regularity. In our own minds we set up certain requirements we would expect the children to live up to and in terms of which we could handle the behavior that might arise. We let the children know what we expected of them on these special trips and this also gave them a gauge. We made use of local parks, museums, theaters, swimming holes, roller rinks, candy stores and factories. Usually we were able to make preliminary arrangements. Even with the most elaborate pre-planned activity, where excitement and stimulation were carefully minimized, there could still be an unpredictable element that would drive the entire group into bedlam.

Even when a group had made a fairly successful trip and seemed satisfied, problems might

arise on the return trip to the ward. In the confines of a station wagon, group tension seems to mount and in the necessarily close proximity the youngsters often clashed. In order to avoid the consequences of these tense feelings, many props and tricks were used as preventive measures. Games which focused attention outside the wagon, such as counting and identifying foreign cars, counting mail boxes, and so on, directed their interests away from the close quarters. On particularly long trips a bag of candy and a good supply of comics helped ward off restlessness when games grew tiresome. Singing was always a good device as long as the group was in a good mood. Once the mood changed it was best to steer away from songs, which often turned into vulgar chanting.

These are only a few examples of how space was utilized in the total program. It is only after we have some grasp of the concepts of timing and space utilization that we can begin to assess the function of content. This in turn is a vital ingredient in a therapeutic program. Content means what we employ, what we make use of at a given time and place. It was through our manipulation of content that we were able to use specific means to attain desired, predetermined goals. It was in learning what content to use that much of our most stimulating thinking was done.

In one study on interpersonal behavior, it emerged that the interaction between a disturbed child and an adult varied in intensity according to what they were doing and what control they were using. During periods in which the adult was seen as the key person, as in craft activities, there was less hostility displayed toward the adults and the peer group. On the other hand in more unstructured activity, such as informal social settings, hostility toward both adults and peers ranked high. In such situations, there was a constant bidding for attention on the part of the patients, supplemented by a considerable amount of "scapegoating." Further study showed that, of them all, structured games produced the most overt hostile interactions with adults and peers without destroying the activity structure, which pointed up the possibility that these games could be used to "blow off steam."

One tentative conclusion of this study was that the disturbed child was less capable in role perception and role enactment than were the normal children in the parallel control group. We thus have support for the commonsense conclusion that the more clearly we can communicate the content structure of an activity, whether it be the rules of a game or the details of a project, and the more readily it is perceived by the disturbed child, the more satisfying will be the end result with a consequent reduction in the amount of hostility displayed.

This is specifically evident in arts and crafts where the skill and experience reside largely in the adult in charge. Here the role of the helpful instructor is readily perceived and the child finds it easy to step into his own role of the student who needs to be helped. Continued evaluation of the content of activities led to more and more refined usage and to ever more precise joining of the needs of a particular child to the materials and situations which would satisfy him best. The low frustration level of these children guided us in how to plan everything we designed for them, so that the result would be therapeutic and satisfying.

Not all the children's needs could be handled by rapid-gratification type of behavior. Activities that were more creative but still adult directed fulfilled another need. Familiar mediums such as painting, drawing, play acting, dancing and music gave the youngsters room to experiment with their own spontaneity in non-violent ways; in some instances this alone may have been enough to give satisfying expression to their growth potential and capacity for sublimation.

A major fact of social reality for our children was the ward itself. The youngster was not only haunted by his own problems but he also had a role to play in the ward group and he had to establish and maintain this role. Various games offered him a chance to play different parts, and to work off steam and hostility in a prescribed way. Games with a legitimate scapegoat role such as the "it" games were not only acceptable but desirable at many crucial moments. Even though behavior was not always predictable in these action-packed games, the space involvement and the motor discharge alone rated high in the impulse drainage that these children needed. In many instances the behavior was predictable and therapeutically useful.

Up to this point I have given a sketchy view of some possibilities of activity programming as a contributing factor in the total treatment procedure for the hyperactive child. In conclusion I would like to tell how we tended to program the day for a hyperaggressive child. Such a child is always in close touch with chaos: unscheduled time, unorganized space, undirected group interactions—all these leave him prone to his strong internal bent toward explosive disorganization. As the child gets up to face the day he may have many uncertainties as to what it holds in store for him. To cope with this, every day we posted the next day's plan on the bulletin board, with special events and his own individual appointments clearly marked for him. Upon arising he was expected to dress himself and straighten up his room as best he could. If he needed as-

sistance, the counselors were around to give him a hand. As a rule the children were not able to ask for such help and were apt to get involved in peripheral distractions and interactions with their roommates. Hence this was a busy time for the counselors.

Breakfast was served with a male and female counselor in attendance, both of whom sat at the table and ate with the children. Immediately following breakfast, the children met in the day-room around a large table and were told again what activities were scheduled after school and after quiet hour. This strengthened the sense of belonging to a group and offered them some boundaries within which they could function.

The school they attended consisted of several classrooms in the adjoining hallway. While the youngsters were in class one of their counselors sat in the hall outside to catch any "bounces," that might occur from school and to supervise the children's games at recess time. If a child ejected by a teacher was too upset to return to school, he might do his schoolwork in the hall under the counselor's supervision or he might be returned to the ward where he would be picked up by another child-care staff member for a life space interview. After school the children moved back to the ward to make ready for the outdoors, gym, sun deck or whatever was in store that day. The reasons for this mass movement have already been discussed.

After this active period, lunch and quiet hour followed in that order. It took a great deal of training for the children to learn to use the quiet hour successfully. We had set a time of the day when each child was required to go to his room and remain there for approximately one hour. During this interval he could rest, play quiet games, read, be with his roommate and, parenthetically, he could also have an adult to himself.

Immediately following quiet hour, the children were usually more composed and able to take organization, and it was at this point in the day that we generally introduced the more formal games, projects and special events. We found that this was the only time when parties could be carried out successfully and consequently all birthday parties and holiday parties, puppet shows and talent shows were scheduled for this time. We found that even though these were all activities with high excitation potential, at this stage in the child's day they could be carried out with success. Parties became our best teaching tool for orienting new counselor staff members. By involving them in the pre-party plans and having them carry through with these plans, the methods and techniques we used to meet the children's needs could be easily pointed up. It gave them a picture in miniature of how we approached the total life of the child.

At 3:00 p.m. we had to help the child cope with the change of shifts. For the youngsters it meant breaking off their contacts with one group of child-care staff and engaging in relations with another. To support the youngsters at this point, a social hour was held. Thus the oncoming evening team met with the children in a group, they had juice or milk together and a meeting was held around the anticipated program for the evening. After the meeting and social hour there was a free period during which those children who had individual interests could find time and adults enough to assist them. This was the time that library trips and shopping trips out of the hospital were undertaken. As the children went back and forth between their individual activities and the group, informal games were usually introduced by the counselors. Those wanting to participate could pick up the opportunity, others could continue to indulge in their own pursuits. Then supper and the post-supper games ensued and presently a planned event would be set up by one designated member of the team or by myself. These were periods of well defined activity and would often be repeated weekly. Structure was essential during the pre-bedtime period which was the most disturbing and frightening time of the day. We always played down highly competitive participation and utilized the group to emphasize security, warmth and good fellowship.

Very clear and precise routines were necessary to get through showers and bedtime preparations and we followed these routines strictly. When the children, finally arrayed in their pajamas, arrived for bedtime snacks, they were well prepared for the ensuing procedure. They knew exactly which counselor would be in their room to read to them, which youngster's turn it was to select what would be read, and so on.

This was the way we scheduled the life space of these children. Needless to say there were endless variations and deviations from the framework in order to fit the needs and readiness of the group as well as to adapt to the special problem of this individual or that. When the youngsters' needs were expressed in wildness, destruction or panic, we could still operate within reason and handle the behavior more readily than if we had not had the structure. As we became more sensitive to the "clues" of a case, our patients became more desensitized to the stimuli that triggered them. It was our belief that a gradual, simple relationship characterized by trust could be developed between the child and the adult, and the child's world would grow with every meaningful experience. Planning such experiences for disturbed children as a part of their day-to-day living offers a new horizon to occupational therapists.

Forty-Third Annual Conference

American Occupational Therapy Association

November 10 *to* 17, 1960
Hotel Statler
Los Angeles, California

General Theme

REFLECTIONS AND PROJECTIONS

Program

Conference Committee Meetings

Thursday, November 10

Graduate study committee	9:00 a.m.-12:00 m.
*Council on education	1:30 p.m.- 5:30 p.m.
Graduate study committee	7:00 p.m.-10:00 p.m.
Student affiliation committee	7:00 p.m.-10:00 p.m.
Curriculum committee	7:00 p.m.-10:00 p.m.

Friday, November 11

Graduate study committee	9:00 a.m.- 5:00 p.m.
Student affiliation committee	9:00 a.m.- 5:00 p.m.
Curriculum committee	9:00 a.m.- 5:00 p.m.
*Executive committee	2:30 p.m.- 5:00 p.m.
Joint business meeting (stud. affil. & curr. comm.)	7:00 p.m.-10:00 p.m.

Saturday, November 12

Joint workshop (stud. affil. & curr. comm.)	9:00 a.m.-11:00 a.m.
House of Delegates	9:00 a.m.-10:00 p.m.
International committee	9:00 a.m.-12:00 m.
Permanent conference committee	10:00 a.m.-12:00 m.
Student affiliation committee	11:00 a.m.-12:30 a.m.
Curriculum committee	11:00 a.m.12:30 p.m.
*Curriculum study project	1:00 a.m.- 4:00 p.m.
*Council on education	1:30 p.m.-10:30 p.m.
Comm. to revise manual on org. & admin. of OT dept.	7:00 p.m.-10:00 p.m.
Comm. for recog. of OT assists.	7:00 p.m.-10:00 p.m.
Development advisory committee	7:00 p.m.-10:00 p.m.

Sunday, November 13

*Board of Management	9:00 a.m.-10:00 p.m.
Comm. to revise manual	2:00 p.m.- 4:00 p.m.
Clinical procedures committee	2:00 p.m.-10:00 p.m.
Recruitment and publicity committee	7:00 p.m.-10:00 p.m.

Monday, November 14

Civil defense committee	7:00 p.m.-10:00 p.m.
Editorial staff of AJOT	7:00 p.m.-10:00 p.m.
History committee	7:00 p.m.-10:00 p.m.
Prevocational committee	7:00 p.m.-10:00 p.m.
Recruitment and publicity committee	7:00 p.m.-10:00 p.m.
*Respiratory center OTs	7:00 p.m.-10:00 p.m.
Special project fund committee	7:00 p.m.-10:00 a.m.
Special studies committee	7:00 p.m.-10:00 p.m.
World Federation of OTs	7:00 p.m.-10:00 p.m.

Tuesday, November 15

Development advisory committee	7:00 p.m.-10:00 p.m.
House of Delegates	7:00 p.m.-10:00 p.m.
Legislative and civil service committee	7:00 p.m.-10:00 p.m.
Veterans Administration	7:00 p.m.-10:00 p.m.

Wednesday, November 16

Appraisal committee	7:00 p.m.-10:00 p.m.
*Board of Management	7:00 p.m.-10:00 p.m.

Thursday, November 17

House of Delegates	4:00 p.m.- 4:45 p.m.

*All meetings are open to the membership except those starred.

Conference Program

Monday, November 14

AOTA coffee hour ..... 9:00 a.m.- 9:45 a.m.

Opening session .....10:00 a.m.-12:00 m.

Florence S. Cromwell, O.T.R., presiding

Annual business meeting

Helen S. Willard, O.T.R., presiding

Afternoon session ..... 2:00 p.m.- 4:30 p.m.

"Reflections and Projections:

The Therapist and the Profession"

Vernon L. Nickel, M.D., chief surgeon (orthopedic), Rancho Los Amigos Hospital

Edward J. Stainbrook, M.D., chief, department of psychiatry, Univ. of S. Cal.

Grand opening & tour of exhibits.... 4:30 p.m.

Winifred C. Kahmann, O.T.R., presiding

Tuesday, November 15

Morning session ..... 9:00 a.m.-12:00 m.

"Reflections on Current Practice"

Interim report from curriculum study project

Presentations on current practice by therapists

Eleanor Clarke Slagle lecture

Muriel Zimmerman, O.T.R.

"The Past, Present and Future in the Field of Devices"....11:00 a.m.-12:00 m.

Afternoon session ..... 2:00 p.m.- 4:30 p.m.

Concurrent sessions

Selected papers on current practice

Wednesday, November 16

Morning session ..... 9:00 a.m.-12:00 m.

Projections on Practice

"Research for Therapists"
A. Jean Ayres, O.T.R.

Three papers by therapists illustrating different approaches to research

Discussion and conclusions
A. Jean Ayres, O.T.R.

Schools' luncheon and fashion show .....12:15 p.m.- 2:15 p.m.

Afternoon session ..... 2:30 p.m.- 5:00 p.m.

Projections: The Future of Practice

Report of pilot study on basic approach

Panel: Basic approach vs. specialization

Recruitment exploration

Thursday, November 17

Morning session ..... 9:00 a.m.-12 m.

Projections: The Future of the Profession

Presentation of structure and function of AOTA

Role of House of Delegates

Role of state associations

Responsibility of the individual therapist

Afternoon session ..... 2:00 p.m.- 4:00 p.m.

"The Future of Rehabilitation".. 2:00 p.m.- 3:00 p.m.

Summary and conclusions of the conference ..... 3:00 p.m.- 3:45 p.m.

Closing ceremonies ..... 3:45 p.m.- 4:00 p.m.

Ships Party ..... 5:30 p.m.- 6:45 p.m.

Banquet ..... 7:00 p.m.- 9:00 p.m.

(entertainment to be announced later)

A reduction in conference fees is offered for pre-registration. If you have not received a pre-registration card, write Miss Lois Barber, O.T.R., % Janet Stone, 4435 East Ocean Blvd., Long Beach 3, California. Your early application will aid the local conference committee and will save you time on arrival at the conference.

Plans are being made for tours of occupational therapy departments in the Los Angeles area. If at all possible, confine your visits to the specified times so that the unit will be assured of having an adequate staff to conduct you on the tour. The local therapists will be busy with pre-conference planning so that unscheduled visits will place a burden on the department. If it is impossible for you to visit all the departments you wish to see in the scheduled time, write to make arrangements with the directors of the departments. They are proud of their unit and wish you to visit it but it is convenient for them to know well in advance of the conference that you are planning a visit to their department at a time other than scheduled by the local committee in charge of planning tours.

Queries and Answers

The clinical procedures committee urges that you, the practicing therapist, use this column as a means of getting some help with your perplexing problems. Submit your questions to either Captain Lottie V. Blanton, AMSC, Box 326, Letterman General Hospital, San Francisco, California, or to Miss Irene Hollis, O.T.R., editor, "Queries & Answers," field consultant in rehabilitation, AOTA.

We also invite you to express a difference of opinion to answers given or to supply us with additional information related to any of the subjects introduced here. Make this an organ through which the voice of the clinical therapist can be heard. The success of "Queries & Answers" depends upon your participation.

CASE LOAD

Question: What is a fair patient load per therpist by disability types? G.L.R.

Answer: A specific formula for case load, per occupational therapist, does not exist. There are many variables which enter into the consideration of patient treatment. In evaluating proper case loads for personnel, the following factors should be seriously considered:

1. The type of patient to be treated (disability area)
2. Available and adequate work space and equipment
3. Number of personnel (paid and volunteer)
4. The number of hours per day during which patients may be treated.
5. The number of patients who may be treated in groups, as opposed to the number who must be treated individually
6. The length of treatment
7. The amount of time devoted to teaching and student supervision
8. The amount of preparation time needed.
9. The type and frequency of records, reports and administrative responsibilities required.
10. Community responsibilities required of the therapist, i.e., talks, meetings, demonstrations, exhibits, etc.
11. The amount of time required for counselling and interviewing the patients' families.
12. The time expended in rounds, medical conferences and other related meetings
13. Time expended in planning and scheduling

— From the proposed revision of "Administrative Practices and Personnel Policies."

MULTIPLE SCLEROSIS

Question: I am in need of suggestions concerning ADL and progressive resistive exercises for two blind patients who are diagnosed as having multiple sclerosis. G.H.

Answer: Progressive resistive exercises are not used with multiple sclerosis patients if there is a tremor involved. Instead start with an optimum amount of resistance (determined by trial and error) and *decrease* this amount as the patient's control of movement is improved.

For ADL training, we analyze each act and break it down into the elementary motions of each joint required to accomplish the act. The patient is made to concentrate on one movement of one joint, proximal to distal, in proper sequence. It is a slow process, but it yields rewarding results for the patient who is able to transfer this thinking-acting to his needs of daily living.

— Captain Lottie Blanton,
AMSC, San Francisco

TUBERCULOSIS

Question: Should the therapist, working with tuberculosis patients, who has a negative skin test obtain a BCG vaccination? Clinical Procedures Committee.

Answer Number 1: Currently, there are two general approaches to this question: (1) BCG vaccination to afford resistance to infection from the tubercle baccillus, which would convert skin test to positive; and (2) Mantoux skin test every three months. If conversion to positive does occur, suppressive therapy with INH should be instituted, under medical superivsion.

The therapist with a skin test which is already positive should have chest X-rays every six months to insure detection of any active disease.

— Miriam Scanlan, O.T.R.
Denver

Answer Number 2: The risk of infection and subsequent serious disease is extremely small, so the decision to vaccinate or not is relatively unimportant. By rendering the skin test positive, the vaccination would prevent the use of the test to determine the time of an infection if one should occur. The consensus now seems to be that a tuberculin test every few months is preferable to vaccination.

— Floyd M. Feldman, M.D.
Director of Research
National Tuberculosis
Association, New York

The above is Dr. Feldman's personal opinion and does not reflect any official action on the part of the National Tuberculosis Association.

Letters

To the Editor:

I am impressed with the caliber of all three of the psychiatric articles in the January-February AJOT. Dr. Conte has certainly contributed a valuable and realistic evaluation of the role of the occupational therapist. It is supporters like him who can really help us define and establish our role in the rehabilitation team.

Dr. Conte's comments on the prescription are also worth noting. How many of us have thought in terms of the OT prescription keeping us apart from our medical staff. It has been an uphill battle to get doctors to give prescriptions, and many therapists still work without them. There seem to be several reasons for this which all boil down to a lack of contact or rapport with the doctor. We spend a lot of time establishing rapport with the patients; perhaps some of that time would be well spent establishing rapport with the doctors, and working out ways in which we can cooperate in the patient program. I can see a formal prescription as being much more confining than personal and continual contact with the supervising doctor.

Another interesting point made by Dr. Conte was in relation to uniforms. If we have to depend on uniforms to maintain our professional relationship with patients, our techniques as therapists are surely lacking in effectiveness. The atmosphere of superiority and segregation created by uniforms must truly have a negative effect on patients, particularly those with problems centering around authoritarianism. There are other fields besides the psychiatric setting where uniforms seem to be contraindicated; viz. preschool handicapped children. Here a relaxed and non-medical environment is essential in eliminating the association of the "great white uniform" and "fear" that most of these children have acquired. Many of them have had more than their share of unpleasant doctor, clinic, and office visits, and would have a difficult time adjusting to more uniforms.

Having worked in both psychiatric and preschool cerebral palsy settings I am inclined to agree with Dr. Conte, that the use of uniforms is greatly overdone.

Yours sincerely,
Beth Alderman, O.T.R.
Spastic Children's Clinic,
Seattle, Washington.

June 30, 1960

To the Editor:

I was very pleased to see Miss Willard's report on the Independent Living Bill (H.R. 3465 and House Joint Resolution 494) in *The American Journal of Occupational Therapy*, Volume XIV, May-June, 1960.

Since January 27, 1959, when Mr. Elliott introduced the bill, which was referred to the committee on education and labor, a great deal of study has been done. As reported by Miss Willard, hearings have been held in several different regions to consider these bills as well as H.R. 1119 and H.J. 488, bills regarding the field of special education and rehabilitation. Reports of the hearings in three areas have been published and are available from the Government Printing Office. These are Part 1, hearings held in New York, N. Y., October 28 and 29, 1959; Part 2, hearings held in New Haven, Conn., December 17 and 19, 1959, and Part 3, hearings held in Cullman, Alabama, January 27 and 28, 1960.

Mr. Graham A. Barden, chairman, committee on education and labor, directed that an inventory of federal services to special education and rehabilitation be compiled. Part 1 of this study (printed for the use of the committee on education and labor) was published in February, 1960.

In the foreword, Mr. Barden says "The federal government has in some measure been engaged in providing special education and rehabilitation services to the disabled of this country for over a century. During the past two decades the federal service programs of special education and rehabilitation have taken on a new and expansive dimension. Appropriations for the direct and indirect services to these fields appear in 29 departments, agencies and bureaus of the federal government. The appropriations for 1959 for all these fields are substantial, approximately $271,756,902. Each Congress witnesses the introduction of an increasing number of bills seeking in one way or another to provide additional services for the child or adult—handicapped or in some other way exceptional—who deviates from the normal or average individual. The size and complexity of this problem, the lack of complete knowledge of what the federal government is now doing in all these areas, and the necessity of determining some priority of meeting future needs made it imperative that this committee, which has jurisdiction over a substantial number of these matters, secure as complete a compilation of the laws, regulations, and service programs covering these areas as possible. The subcommittee on special education, under the chairmanship of Carl Elliott of Alabama, undertook the task of conducting this study. This volume (part 1 of the study) should prove of lasting value to members of Congress, professionals, and the general public who wish to know just what the federal government provides for exceptional and handicapped children and adults."

In order to index the categories of the exceptional conditions included and authorized by statutes, the committee used the following categories in the report:

Visual impairment
Hearing impairment
Defective speech
Neurological disorders
Orthopedic handicaps
Infectious disease
Special medical and health problems
Mental retardation
Giftedness

As a result of the study thus far, Mr. Barden introduced H.R. 12328 on May 23, 1960. This is a bill "to extend and improve the special education and rehabilitation services provided by the federal government."

Section 101 declares that the purpose of the act is to effect, through coordination, reorganization and transfer, the more efficient operation of federal programs for special education and rehabilitation of the handicapped thereby making more manpower available for defense and otherwise promoting the general welfare of the nation.

Section 102 defines terms used throughout the bill.

Section 103 creates within the Department of Health, Education and Welfare an agency to be known as the "Agency for Special Education and Rehabilitation" and states that within the agency there shall be a Division of Rehabilitation and a Division of Special Education.

Section 105 establishes an "Interagency Council on Special Education and Rehabilitation."

Section 106 transfers certain functions.

Section 107 contains amendments to the Vocational Rehabilitation Act which expand authority for the Divi-

sion of Rehabilitation within the Agency for Special Education and Rehabilitation to provide services to handicapped people which would assist them to achieve a degree of independence that would eliminate or reduce the need for institutional care or an attendant's care.

Sections 202 and 203 authorizes the secretary to award support grants and fellowships to people in the field of special education.

Other sections of the bill are equally interesting and comprehensive. One feature is the amendment of the rehabilitation act by striking out the word "vocational" throughout and inserting "special education and rehabilitation" or just rehabilitation where applicable.

There is no doubt that this bill will pass during the current session of Congress, however, its implications for occupational therapy are such that it should behoove all occupational therapists to study not only H.R. 12328 but all other related documents which led to the introduction of the bill.

I hope that the American Occupational Therapy Association will soon take the lead in defining the function of occupational therapy in the many areas in which services can be rendered. This should most certainly be the first step in determining future functions and goals of our profession which has contributed in some measure to rehabilitation in its broadest sense since 1917.

H. Elizabeth Messick, O.T.R
Member of the Board of Management.

June 27, 1960

To the Editor:

President Willard reminds us, in her most recent Nationally Speaking column, of an obligation to investigate and urge congressional support of HR 3465, commonly known as "The Independent Living Bill."

There is no question that the liberalizing intent of this bill opens the door to increased rehabilitation services for legions of handicapped people who may previously have been excluded from consideration by state rehabilitation agencies because of limited vocational potential. Under the proposed law, the division of vocational rehabilitation in all states would, for the first time, be permitted to sponsor greatly enhanced programs for those disabled persons who are not necessarily good vocational risks.

This certainly has all the earmarks of Utopia to many of us who, for years, have argued the cause of vocationally infeasible clients in an attempt to secure essential services.

On the other hand, there are a number of factors operating to becloud the issue and these need to be squarely faced in the months of grace before HR 3465 becomes law. I do not profess to know the answers to these problems but do believe we must recognize them if we expect to capitalize, nation-wide, on the proposed legislation.

There is, first, the acute and unrelieved problem of personnel shortages. If HR 3465 goes into effect, it must be accompanied, as Miss Willard points out, by substantial funds for recruiting and training appropriate personnel to implement the stipulations. Our personnel tribulations exacerbated with the sudden sharp spiral of rehabilitation center development; they will multiply many-fold as HR 3465 becomes a law.

In this connection, it is interesting to note that some supporters of the bill call for the creation of "new professional groups" to provide services outlined; i.e., "Vocational Rehabilitation Counselors in Homemaking." This suggestion is predicated on the fact that rehabilitation of the homemaker "cannot ordinarily be achieved without several home visits and a careful study of the home management of each family." We may well question whether a new "breed of cat" is really indicated for this purpose and on the basis offered. It should be remembered that new bills are, traditionally, a happy hunting ground for the opportunist and may create in their wake a confusion dictated by the absence of time for reflective thought.

Secondly, we may want to concern ourselves with who will become finally responsible for administering this bill. To date, three powerful agencies appear to be vying for the questionable privilege; they are: the Office of Vocational Rehabilitation, the Welfare Department and the Labor Department. Ideologically, it would seem sensible for the first of these to handle administration of the bill. In terms of experience and avowed purpose, OVR has the advantage. Its emphasis, its policies, its procedures and channels (if not always its performance) are already adapted to such an expanding function.

Thirdly, we may want to insure the provision of accompanying orderly and intelligent state procedures and policies for expediting the proposed programs. (Therapists who were caught up in the tremendous rehabilitation center movement during the past 5-10 years can recall some of the confusion at state level occasioned by the excellent federal legislation). As the law presently reads, there is little if any assurance of the primary use of existing facilities and their expansion, before others are constructed. Without a seasoned and knowledgeable state advisory council, we might well see a mushrooming of the sheltered workshops proposed in HR 3465, as a penny-wise but pound-foolish panacea for placement of non-competitive workers. There is little substantial documentation of the national need for sheltered workshops. We do not yet know what traffic in sub-contracting industry will ultimately bear, both in terms of total product and in potential nuisance-value to the contractor where a multiplicity of small outfits compete for business in a given locale.

Over and beyond this, we might devote some serious thought to the fact that, in creating a potential flood of workshops, we are indirectly but none-the-less effectively removing the burden of challenging placement from individual agencies and communities which have yet to come to grips with it. If we are to have more facilities, we must simultaneously insure more and skilled personnel as well as enormously increased effectiveness in achieving selective placement of the handicapped by the agencies entrusted with this function.

The writer will almost certainly be accused of provincialism and lack of faith for the harboring of such doubts and cautions. Or, it may be maintained that these reservations obtain only in Connecticut and lack validity for the country as a whole. Let it be said for the record that experience has unfortunately supported the universality of some of the reservations expressed here. Unless we, as citizens and therapists, are concerned enough to qualify with words and action our acceptance of a potentially excellent measure, we shall have no cause to carp when HR 3465 produces dislocations and strains as well as the much-touted benefits.

Sincerely yours,
June Sokolov, O.T.R.
Director
The Hartford Rehab. Center
Hartford, Conn.

MIDYEAR MEETING OF THE BOARD OF MANAGEMENT

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

Plankinton House, Milwaukee, Wisconsin

April 1-3, 1960

Presiding
Miss Helen S. Willard, president

Members present
Genevieve Anderson, O.T.R.
Shirley Bowing, O.T.R.
Mary Britton, O.T.R.
Ruth Brunyate, O.T.R.
Dwyer Dundon, O.T.R.
Gail Fidler, O.T.R.
Ethel Huebner, O.T.R.
Col. Myra McDaniel, AMSC
Martha Matthews, O.T.R.
Elizabeth Messick, O.T.R.
Major Elizabeth Nachod, AMSC
Eileen O'Hearn, O.T.R.
Mary Reilly, O.T.R.
Irene Robertson, O.T.R.
June Sokolov, O.T.R.
Mary Van Gorden, O.T.R.
Beatrice Wade, O.T.R.
Wilma West, O.T.R.

Ex officio
Marjorie Fish, O.T.R.
Margaret Gleave, O.T.R.

Members Absent
Marguerite Abbott, O.T.R. (proxy: Miss Brunyate)
Donna Harper, O.T.R. (proxy: Miss Huebner)
Satoru Izutsu, O.T.R. (proxy: Miss Sokolov)
Barbara Jewett, O.T.R. (proxy: Miss Matthews)
William Dunton, Jr., M.D.

Auditors
Irene Hollis, O.T.R.
Angeline Howard, O.T.R.
Lucie S. Murphy, O.T.R.
Mildred Schwagmeyer, O.T.R.
Carlotta Welles, O.T.R.

President Willard officially welcomed the newly elected Board members present, and Miss Margaret Gleave, treasurer-elect.

It was voted to accept, as circularized, the minutes of the previous meeting of the Board of Management in Chicago, October, 1959, with corrections.

Committee Reports

Special projects fund: Elizabeth Collins, O.T.R. The following recommendations were presented for Board action:

(1) That the committee be authorized to operate according to the SOP as presented at the April, 1960, meeting.

(2) That the committee be authorized to continue present procedures in the handling of undesignated donations to the fund.

(3) That the committee be authorized to establish the same methodology employed in the Virginia Scullin Memorial Fund, as a criterion for any future established memorial funds.

(4) That the Board designate the geographical areas to be used as a basis for the selection of committee members.

(5) At the time projects are being considered for implementation by monies from this fund, that the selection be based on direct clinical application rather than on administrative aspects of the Association's operation.

It was voted to accept Recommendations 1, 2, 3 and 5.

The Board recommended the following changes in the committee SOP: (1) To reclassify *Purpose of Committee* as Item A under *Function of Committee*, relabelling the following functions in sequence; (2) To add *development advisory committee* to paragraph on coordination with other committees; (3) To delete names of individuals and substitute titles throughout; (4) To include mention of a rotation plan in *III, Organization of Committee.*

The value of this committee reporting to the House of Delegates at regular intervals was emphasized.

The report was accepted with appreciation.

Recognition of occupational therapy assistants: Marion Crampton, O.T.R. Advance information circulated to Board members concerned certifications (grandfathers clause) to date (336), aides who have joined the AOTA, training programs approved, and development of a curriculum guide for OT assistants in general practice. The following items were presented for Board action:

(A) Re-certification fee: It is recommended that an annual re-certification fee be established so that this will be in line with the current policy of AOTA with respect to re-registration of the registered occupational therapist.

It was voted to accept Recommendation A, as written.

It was voted that consideration of the amount of the re-certification fee be referred back to the committee for further study.

(B) The committee recommended approval of the newly written curriculum guide for occupational therapy assistants in general practice.

It was voted to accept Recommendation B.

(C) It was recommended that the plans for recognizing and certifying occupational therapy assistants in general practice be implemented in October, 1960.

It was voted to approve Recommendation C.

It was suggested that announcement of training and certification in this area be sent to AOTA complimentary mailing list and to members through the Newsletter.

The report was accepted with appreciation.

Permanent conference committee: Winifred C. Kahmann, O.T.R. A meeting was held in national headquarters, January 23/24, by the study committee for reorganization of annual conference operation. Summary of the revised SOP was circularized to the Board and is anticipated for distribution at the 1960 annual meeting. The committee supported the Board recommendation on employment of a conference coordinator when financially feasible.

Clyde Butz, O.T.R., has accepted chairmanship of the conference appraisal subcommittee, and membership on the permanent conference committee for three years. The theme of the 1960 conference will be "Reflections and Projections" and will be therapist-centered. A $1.00 reduction in fee was suggested for pre-registration for the 4-day session.

The Board approved the suggestion that the conference program committee explore the possibility of having a session of the program each year devoted to one of the AOTA committees and presented by them.

Further Board opinion was requested with regard to the screening of papers written by O.T.R.'s prior to their presentation on the conference program. The 1960 program committee has prepared a form and cover letter for applications. (See these minutes under "Other Business.") It was suggested that AOTA committees be utilized such as special studies and clinical procedures in selection of papers. General Board approval was indicated.

Invitations were received from Texas and Ohio for the 1961 midyear meeting; from Florida and Colorado for the 1964 annual conference.

It was voted to hold the 1964 annual conference in Colorado.

Legislation and civil service committee: Marjorie Fish, O.T.R. (for Virginia Caskey, O.T.R.). It was indicated that salary range information has been reproduced and sent out in response to inquiries. This data has been used in establishing professional ranges on the fact sheet. The Board indicated acceptability of coding information by state and type of institution rather than by number.

For action on malpractice and misrepresentation see the report from the executive committee in these minutes.

The report was accepted with appreciation.

Development advisory committee: Wilma West, O.T.R. An informational report was given inasmuch as no Board action was required. Local responses received have been excellent in their affirmative and supporting nature. Additional areas of study on AOTA structure and function have been undertaken: Board of Management, executive committee and officers.

Recruitment and publicity: Frances L. Shuff, O.T.R.; Julia Hardy, director of public information. A progress report on the 1960 regional workshops was presented. The chairman indicated presentation of a documented report dealing with the over-all recruitment program at the June Board meeting. The problem of immediate concern is one of financial support for work of this committee at the state's level and the possibility of promoting fund-raising in the states.

Discussion upon completion of the report, and later in connection with the report of the treasurer, emphasized various possibilities on raising of funds to subsidize the work of the committee. It was agreed, in general, that the status quo should be brought to the attention of the states through the House of Delegates, for their thinking, and that the possibilities of further grant awards should be investigated on all levels, local and national.

Executive Reports

Report of the treasurer: Wilma West, O.T.R. The proposed 1960-61 budget had been presented to the executive committee and circulated to the Board as a balanced budget carrying an additional item under revenue "Transferred from Reserve Funds." The following change was recommended: that a deficit budget be presented, instead of utilizing the reserve fund to achieve a balanced budget, as a means of clarification and understanding for the membership, and that a deficit of approximately $6,000 be evidenced.

Increased expenses were attributable to salary increases; expenses incurred by and for committees, House of Delegates, executive committee/Board; and allowances for actual and potential additional staff. Board members were urged to interpret the budget to the membership in their local areas.

The treasurer will investigate the possibility of tax exemptions on travel expenses for use of members in submitting travel reimbursement vouchers.

It was voted to adopt the report as recommended by the executive committee and presented by the treasurer.

Executive committee: Helen Willard, O.T.R.

1. *Curriculum study project.* It was announced that Miss Marguerite Abbott, due to ill health, had resigned as director of the project, but would remain on part time to complete her particular phase of the work. The executive director will serve pro tem on the project until July 1, when Miss Wilma West will assume the directorship. No additional grant funds are anticipated, but the schedule for completion of the study will probably have to be extended by several months.

2. *Grant request for director of professional development.* Board discussion dealt with delineation of the scope and focus of the position, functions and areas of activity, and mechanics of implementation. It was felt that the draft of the proposal limited its function to the handling of grants only. A position of this character should also include emphasis on improved facilities and services which would be reflected in better patient care rather than so much of internal structure and function.

It was voted to seek the grant as currently written up and described. It was suggested that the title be changed to grant administrator. After further careful scrutiny, Board members are to submit their recommendations on the scope and content they conceive as necessary to convey the image of what the professional development position should be. These are to be sent to the national office by May 1.

3. *Policy on union membership.* Following inquiry from several members and state associations requesting information as to policy on union membership, investigation was made among other professional groups and through the House of Delegates. Findings from all sources were substantially negative and opposed to union membership and considered the national organization as the member's best protection for providing the necessary adequate standards. The executive committee recommended that complete returns from the House be awaited. *The Board indicated that,* pending receipts of specific House material, there could be assumed a policy of opposition to unionization.

Malpractice and group insurance. Following recommendation at the winter interval executive committee meeting, legal advice has been sought with regard to malpractice insurance and group insurance with subsequent data received from insurance counselors indicating the feasibility of coverage. Many professional associations make insurance available for their members under the True Group Plan which operates through the association to the members at no cost to the association. These plans include health and accident, income protection, major medical and major hospital. Different combinations of insurance programs appropriate to the particular professional group involved are usually determined through a survey of the membership.

Malpractice or professional liability, can be included in group insurance plans with variation in different states. *Misrepresentation,* not malpractice, is the difficulty most frequently encountered by AOTA members.

The executive committee recommended to the Board and House that a survey of the membership be conducted to inform them of the specific types of coverage and costs and to determine their interests and particular desires in the matter. The Association Service Office of Philadelphia (insurance counselors) has indicated interest in preparing the material and handling the survey.

The Board agreed that the survey should be made after the speaker has contacted the chairmen of the House committees on group insurance and malpractice to inform them of the utilization of their excellent material.

Misrepresentation. All authoritative opinions agree that without licensing there is no official or legal recourse for us. It is a matter of intensified education to prevent misrepresentation. The legislation and civil service committee has received numerous inquiries on the subject. *The Board recommended* this problem as appropriate for concentrated effort on the part of this committee suggesting that the states be asked to pool their experience for exchange purposes. *It was agreed* that guidelines be framed to support their work. Because protection of standards would be an inherent part of the problem, a possible change of name was mentioned.

4. *Independent Living Bill.* The provisions of the Independent Living Bill, H.R. 3465, will be set forth in an AJOT "Nationally Speaking" column by President Willard. Consensus from state association representatives attending the public hearings conducted through the congressional subcommittee questioned the wisdom of allocating large sums for facilities without previous provision for training personnel. The president indicated that her article would signify approval of the Bill, qualified by specific recommendations to strengthen the

position of the AOTA and the professional field. An editorial approach was encouraged with follow-up through the Newsletter and Letters to the Editor. It was agreed that we must view this Bill, designed for independent living for the severely handicapped, as citizens as well as professional therapists.

5. *Additional two-day Board meeting.* The executive committee recommended an additional interval two-day Board meeting to be scheduled for reports, preferably in June. The annual Board meeting would be devoted to policy matters only. The Board discussed appropriate subject matter for this meeting, and there was consensus that all types of business should be handled at an interval meeting, without attempt to departmentalize the agenda.

It was voted to accept the executive committee recommendation for an additional interval Board meeting, to be held in the national office, with deletion of "for reports" and "the annual Board meetings would be devoted to policy matters only." It was suggested that this be a pilot plan for this year.

Report of speaker, House of Delegates: Ethel Huebner, O.T.R. Final vote by state associations on moving the national office from New York City has been tabulated. Results: 29 associations voted against the move; 8 associations voted for the move; 2 associations reported no vote.

The vice-speaker has revised the form for use in preparing the states' annual reports, and the revised forms will be distributed shortly.

Job description of the speaker has been submitted.

No reports from House committees to be made at this meeting.

Report of editor of AJOT: Lucie S. Murphy, O.T.R. The principal issue reported by the editor concerned publishing of the 1959 conference proceedings, which need drastic abstracting for printing in a regular conference issue of AJOT. Publication of a separate volume apart from AJOT was suggested. *Board consensus* approved selection of best articles to be printed in the regular AJOT conference issue.

Report of executive director: Marjorie Fish, O.T.R. Agenda items represent issues needing consideration. The current listing of facts and figures indicate status of the new inactive membership category. Administration of grants continues to absorb time. The OVR grant for graduate level traineeships, handled through the graduate study committee, is being well handled with good response. National Foundation teaching fellowships are currently available.

An invitation has been received from the American Academy of Orthopedic Surgeons for an AOTA representative to attend a portion of their executive committee session. This was arranged through Dr. Frank Stinchfield, member of the AOTA medical advisory council. Miss Beatrice Wade, first vice-president, will represent the Association.

The executive director and Miss Martha Matthews attended the two-week leadership training course given by the National Training Laboratories for executives of national organizations at Williamsburg.

Field consultant in rehabilitation: Irene Hollis, O.T.R. The field consultant reported that her advisory committee had made the following recommendations:

(1) That subgroups of existing committees be vested with responsibility of investigating OT in public schools and nursing homes and that they formulate a tentative statement of policy and standards for each, to be referred back to the Board. Further, that state associations be encouraged to interpret these policies to the appropriate bodies within their states. *There was Board consensus* that the clinical procedures committee is the logical committee to begin the formulation of standards, and recommendation was made that they proceed on the broad concept which this can represent as an important public health policy measure.

(2) The Office of Vocational Rehabilitation suggested that the AOTA consider conducting a workshop on the teaching of pre-vocational evaluation and training in schools of occupational therapy. The committee recommended that the Board accept this proposal for financing and that regional institutes be held involving therapists and counselors from departments of vocational rehabilitation.

There was Board consensus that appreciation be expressed and a definite indication of the desire to further investigate for careful long-term planning and preparation with vocational counselors to assure mutual benefit to both groups. It was felt that this might be patterned on the Allenberry plan.

Board opinion was requested on utilization of curriculum study findings in this connection. It was felt that the Association's reply to the OVR regarding correlation between the two should indicate the availability of material which would make the relationship clear.

(3) Sharper definition of the role of the consultant was sought. It was suggested that she formulate a statement in terms of her concept of the job based on her experiences and evaluation of the needs met and not met; that she submit this statement to her committee members for recommendations; that this then be submitted to the Board as a specific job description. The Board indicated that the needs as perceived must come from the consultant to serve as a base for further recommendations.

Council on education: Angeline Howard, O.T.R. Board action was requested relative to financing of a key-sort card system to provide classified information on AJOT articles prepared by Cornelius Kooiman, O.T.R. It was suggested that 100 sets of 500 cards each be printed for use by membership, libraries and other appropriate sources.

It was voted that funds for financing printing of the key-sort card system be made available from the AOTA publications revolving fund, with the final cost to be determined by Mr. Kooiman, the treasurer and the national office.

Other Business

Yearbook proposal. North Shore Publishing Company submitted a bid for printing the Yearbook in a format similar to AJOT and at less expense than the current book. The Board requested that a competitive bid be secured from our current printer and indicated that any economical reduction would have to be considered. Final action will be taken at the 1960 annual meeting.

Correspondence. A letter was received from the Ohio State Division of Mental Hygiene inviting AOTA to send an official representative to an anticipated series of conferences in conjunction with the study grant for which they have applied: "Development of Curriculum for Activities Therapy." Board discussion dealt, in considerable detail, with the ramifications and broad implications of the rapid emergence of the activities therapy concept; with the role, position and stand which the AOTA should take in this matter; with the channels and sources of recognition and support through which we should work.

It was agreed:

1. That we accept the Ohio invitation and send an official AOTA representative and that we indicate the importance of stating our viewpoints in relation to activities therapy.

2. That the agenda of the June interval Board meeting carry an item on the relationship and position of OT in this field and that ample time be allocated for free and thoughtful discussion.

3. That a member of the subcommittee on psychiatry of the clinical procedures committee be present at the June Board meeting during discussion of No. 2 above.

Midyear meeting, 1961. Invitations were received from Texas, Florida and Ohio OT Associations. The two southern localities would represent involvement of more time and expense because of distance than the mid-central location usually adhered to. Reference was made to the several meetings held in the past in the more distant areas and the help and benefits resulting for the region. *The Board requested* that a census of preference be taken among the education committees involved, with final decision to be made at the June meeting.

Meeting adjourned.

Respectfully submitted,
Marjorie Fish, O.T.R.
Executive Director.

Delegates Division

DAKOTA

Delegate-Reporter, Lillian Greenstein, O.T.R.

Occupational therapists in the Dakotas are generally located in three geographic areas: Eastern North Dakota; Sioux Falls, South Dakota; and the Black Hills, South Dakota.

The North Dakota group has seen the most substantial growth and they have organized the Red River Valley District of the Dakota Occupational Therapy Association. Primary stimulus to this growth is the enthusiasm of the University of North Dakota Occupational Therapy School. The Red River Valley occupational therapists meet monthly and their activities have included:

(1) Decorating and selling twenty-four dozen Santa goblets.

(2) Using the funds from this project to sponsor a high school essay contest on occupational therapy.

(3) Disseminating information on occupational therapy through letters to 4H Club presidents and Homemaker's Club leaders offering services for tours, talks and demonstrations.

Margaret Rood demonstrated the Rood techniques of neurophysiological facilitation at the annual spring DOTA conference, in Sioux Falls. Occupational and physical therapists from the Dakotas, Minnesota and Nebraska attended.

Occupational and physical therapists in the Black Hills area met in Rapid City, December 12, 1959, to plan a joint spring conference for the Dakota Occupational Therapy Association and the South Dakota Physical Therapy Association. The theme of the program will be "The Neuropsychiatric Approach to Physical Medicine."

OFFICERS

President	Boyd N. Johnson, O.T.R.
Vice-President	Rita C. Gully, O.T.R.
Secretary	Leland C. Bowles, O.T.R.
Treasurer	Aleta Guindon, O.T.R.
Delegate	Lillian Greenstein, O.T.R.
Alternate Delegate	Vacancy

DISTRICT OF COLUMBIA

Delegate-Reporter, Arvilla D. Merrill, O.T.R.

The District of Columbia Occupational Therapy Association has been concentrating for the past several months on community resources. In October, Miss Josephine Albrecht of the council on rehabilitation, Medical Society of the District of Columbia, presented a survey of the rehabilitation facilities available in the District. At the November meeting we had a showing of the film, "The Glass Wall," following which Miss Ruth Hudnut, director of the Washington Hearing Society, added remarks and answered questions concerning this area of disability.

At our first meeting of 1960 in January, Miss Marjorie Fish, executive director of the American Occupational Therapy Association, answered questions about the function of the national office and the activities of the personnel involved. No meeting was held in February because the January meeting had been late.

In March we made a visit to Woodley House, a local convalescent home, with Miss Joan Doniger, director, explaining the operations of this halfway house, the half-way in this case referring to recovery. April is the month for income taxes, spring flowers and rains, and in the District of Columbia Association it brought our annual meeting, with reports of committees and election of officers.

OFFICERS

President	B. Joan Bellman, O.T.R.
Vice-President	Capt. Arvilla L. Dyer, O.T.R.
Secretary	Barbara Itoman, O.T.R.
Treasurer	Marjorie A. Conway, O.T.R.
Delegate	Arvilla D. Merrill, O.T.R.
Alternate Delegate	Ilse R. Achter, O.T.R.

OHIO

Delegate-Reporter, Wilma K. Morrow, O.T.R.

The members of the Ohio Occupational Therapy Association are greatly concerned with the question "Where Are We Going as Occupational Therapists?"

As a result, approximately 85% of our membership met in joint district sessions in June of 1959 to study the material which emanated from the mid-year Board of Management-House of Delegates meeting in Indianapolis and have continued the discussions throughout the year in the various district meetings.

Realizing that further diagnosis of our "growing pains" was necessary and that medication (sedatives excluded) with probably some surgery was indicated, it was decided to center the attention of our annual meeting in May on further catharsis and brain storming. Through our workshops and with the assistance of Miss Shirley Lewis, the Ohio member of Miss Wilma West's development advisory committee of the American Occupational Therapy Association, we expect to do some clear, constructive thinking about the question and hope to find some of the answers. Miss Lewis, Dr. Charles D. Feuss, Jr., Wilma K. Morrow and John Caprio will be the chief program participants.

"They said it couldn't be done" but—thanks to the enthusiastic efforts of the Cincinnati District, the Board of Management and the state officers—we have purchased a professionally designed display board. This helps to fulfill our long-felt need for more public information and, at the same time, gives us an available, useful tool (see AJOT, Vol. XIV, No. 2, page VI). The display board was used for the first time as a part of educational exhibits at the 1959 Ohio state fair in Columbus. It is now available for use by the various districts for recruitment and public information purposes.

A request has come from the Ohio Tuberculosis Association for the Ohio Occupational Therapy Association to plan a program for the training of occupational therapy activity workers in the field of tuberculosis. Recognizing the need for such a program, a committee of ther-

apists is meeting in the spring to plan a pilot program, under the able leadership of Mrs. Anne Allen, O.T.R., who has done considerable ground work for this project.

OFFICERS

President ..... Margaret K. Mathiott, O.T.R.
Vice-President ..... Marjorie J. Karns, O.T.R.
Secretary ..... Kathleen A. Hoovler, O.T.R.
Treasurer ..... Charlotte A. Burpee, O.T.R.
Delegate ..... Wilma K. Morrow, O.T.R.
Alternate Delegate ..... Nancy H. Vesper, O.T.R.

DISTRICT CHAIRMEN

Cleveland ..... Charlotte Burpee, O.T.R.
Columbus ..... Xylpha Schwehm, O.T.R.
Akron ..... Margaret C. Dieringer, O.T.R.
Dayton ..... Minnie A. Fevold, O.T.R.
Cincinnati ..... Catherine A. Peffer, O.T.R.

TEXAS

Delegate-Reporter, Irene G. Robertson, O.T.R.

It is never possible in public relations and recruitment efforts to draw a straight line from cause to effect. However, we do build year by year on the efforts that have gone before.

The color, sound film on the Occupational Therapy School at Texas Woman's University financed by the Tandy Leather Company is now completed. This is a beautiful film showing campus highlights as well as classes and preclinical experiences of student occupational therapists. It is aimed at the high school student and we feel will be a most effective addition to our recruitment armamentarium. We are indeed grateful to Mr. Tandy and the Tandy Leather Company.

We were also fortunate in having an excellent American Hospital Association institute for occupational therapists held in Waco last spring. Our annual state meeting followed the institute and also presented an excellent educational program. There was also a new innovation in scholarship fund raising efforts. We had a hat exchange bar. If you brought a hat you could purchase a ticket which entitled you to "buy" the hat of your choice. There was also the raffle of a hat sent to us by Hedda Hopper. This year we are having a jewelry exchange and raffle of a set brought back from Italy by one of our members.

The H. E. Butt Foundation and Mrs. Butt in particular, has been a wonderful supporter of occupational therapy in Texas. They have given us a grant for an institute on rehabilitation for medical administrators and clinical directors of large institutions for the chronically ill. The Texas Medical Association and the Texas Hospital Association will cosponsor the two day institute to be held in the fall of 1960 at the Texas Medical Association library in Austin.

OFFICERS

President ..... Mary Alice Coombs, O.T.R.
Vice-President ..... Rose Elliott, O.T.R.
Secretary ..... Alice A. Curd, O.T.R.
Treasurer ..... Ruth Whipple, O.T.R.
Delegate ..... Irene G. Robertson, O.T.R.
Alternate Delegate ..... Hope Kenney, O.T.R.

DISTRICT CHAIRMEN

North Texas ..... Marjorie Bracken, O.T.R.
Central Texas ..... Barbara Pickett, O.T.R.
South Central Texas ..... Lt. Ron Bailey, O.T.R.
South Eastern Texas ..... Jean C. Dillon, O.T.R.
Rio Grande Valley ..... Jeanene Ward, O.T.R.

Reviews

AN APPROACH TO OCCUPATIONAL THERAPY. Mary S. Jones, M.C.S.P., M.A.O.T. London, England: Butterworth and Co., Ltd, 1960, 245 pp.

Mrs. Jones has made a real contribution to the field of occupational therapy by her recently published book, *An Approach to Occupational Therapy.* As senior occupational therapist at Farnham Park Recuperation Home she is well qualified to present this study of occupational therapy in the rehabilitation of short term cases. The material presented is based on the observation of 4,115 patients treated from October, 1947, to December, 1955.

The book includes a discussion of disabilities of the following parts and their treatment: injuries to the spine, the lower limb, the upper back, head injuries, lungs, thorax and abdominal disorders. There are two excellent sections, one on muscle movement and posture, and the other on occupational therapy and posture. One of the most interesting sections of the book is that on adapted equipment. There are good working drawings as well as pictures of the special equipment used. Mrs. Jones is well known for her ingenious adaptations. These are now made available to the field.

As Farnham Park was established to serve the industries in the Slough area near London, there is close coordination between occupational therapy and the job to which the patient returns, or if this is impossible then retraining for another job.

This book will be of real value to the occupational therapist working in the field of physical rehabilitation and for all student occupational therapists.

—Clare S. Spackman, M.S., O.T.R.

OCCUPATIONAL THERAPY IN PEDIATRICS, A STUDENT MANUAL. Carol J. Schad, O.T.R., and Anne T. Dally, M.S., O.T.R. Dubuque, Iowa: Wm. C. Brown Book Company, 1959, 79 pp.

This spiral bound booklet written primarily for students offers a well written text with thought provoking questions. There is an introductory discussion of background factors which influence treatment in the pediatric setting. A clear, concise but full account of psychosocial physical aspects which affect growth and development was written by Anne Dally. Treatment is discussed as it relates to children with different types of physical restrictions and emotional problems. There is a portion concerned with techniques of discipline and another covering the use of self and the meaning of play at different developmental stages. Cases are used to illustrate general concepts and questions are raised concerning them and the selected readings. The well chosen bibliography provides additional relevant material.

—Jane Trout, O.T.R.

JOURNAL OF CHRONIC DISEASES, II:5 (May) 1960.

This issue is devoted to a symposium on the problems and management of chronic illness and the statistical problems in medicine. Subjects cover the "Classification of Disease," "The Distribution of Disease in the Population," "The Clinical Trial," "Evaluation of Preventive Services," "Indices for the Appraisal of Health Department Activities," "Some Aspects of Retrospective Study," and "The Household Interview Survey as a Technique for the Collection of Morbidity Data."

The symposium recognizes that the control of chronic diseases is dependent on the identification and quantification achieved through statistical evaluation which develops new means of identifying variable situations affecting disease patterns in the community.

GUIDE TO MODERN HOBBIES, ARTS AND CRAFTS. Bill Newgold. New York: David McKay Company, 1960, 289 pp., $4.50.

A new approach to an old subject. The author is obviously a highly practical and skilled writer. The three main headings (Hobbies, Arts, Crafts) present dubious definitives but are no doubt needed for ease in organization. However the introductory surveys of the subjects under these headings make extremely interesting reading. The author omits the saccharine touch too often prevalent in books on hobbies.

This is not a how-to-do-it book but a survey of more than eighty popular activities. It includes new trends of importance with emphasis on what-to-do and why.

Occupational therapists will enjoy reading this book as well as finding the material helpful in broadening an activity program.

THE SEARCH FOR PROFESSIONAL STATUS. Robert K. Merton. *American Journal of Nursing*, 60:5 (May) 1960.

Occupations seek professional status because society grants special recognition to professionalized groups and the professions themselves decide what they are to do. Therefore professional status grants distinctive and highly prized social recognition.

A single member can not shape a profession, rather the course is determined collectively. The professional association must continually seek higher levels of achievement through new knowledge. "The formulation of high standards is of course no easy task, if the standards are to be more than idle dreams."

RESIDENTS OF HOMES FOR THE AGED. Franz Goldmann, M.D. *Geriatrics*, 15:5 (May) 1960.

A large-scale study of residents in homes located in different geographic regions which presents a composite picture of 530 residents. More senior citizens applying for admission to homes suffer from prolonged illness or permanent disability, fewer want a sheltered life in a home. Therefore more concern must be given to long-term care for "impaired adults regardless of age. As a corollary, old people capable of self-care or requiring only some help should be housed in apartments close to the institutions in order to assure ready access to health services."

TOWER—Testing, Orientation and Work Evaluation in Rehabilitation. Written and published by the Institute for the Crippled and Disabled, 400 First Ave., New York, 1959, pp. 131.

Since 1936, the Institute has been measuring vocational potential through the work sample technique. This book provides a background of this technique and provides instruction and guidance in setting up and operating a TOWER vocational evaluation unit. The entire TOWER system is designed to provide an effective reliable method of judging client vocational capacities.

"Work samples are presented to the client in a series of tests which explain the task to be performed and require client response. The evaluation is provided with detailed printed criteria and other aids for rating client performance. Standardized printed forms are used to record results achieved as well as the observations made by the evaluator of the client's work and personal characteristics."

The 13 broad areas of vocations evaluated by TOWER may not be all-inclusive nor do the statistics presented which support TOWER accuracy seem sufficient to draw conclusions from. Nevertheless, since this book was not written to justify its method, this shouldn't detract from the value of the TOWER concept.

The book is a must for all occupational therapists receiving pre-vocational or vocational evaluation prescriptions. One may conclude that such prescriptions cannot be followed unless the therapist is completely oriented to a system like TOWER, and has a shop equipped to employ such a system. Although TOWER was designed for disabled people, such a plan may have considerable merit in a program of counseling for regular high school students.

—Lester M. Brower, M.A., O.T.R., R.P.T.

CHILD GROWTH AND DEVELOPMENT. Bulletin of the Wisconsin State Board of Health, January-March, 1960.

The issue of this quarterly bulletin is devoted to health in relation to the child. Dr. Abramovitz discusses "What Is Child Health?" Norma Smith, O.T.R., says "Children Have Crises, Too!" And Miss Sanders from the State Board of Health writes about the impressions children gain about health.

There are twelve articles in all in this small bulletin of 36 pages. None of the articles are therefore long but the material is a good compilation pertaining to child growth and child health.

RECENT ADVANCES IN PUBLIC HEALTH. J. L. Burn, M.D., D.Hy., D.P.H. Boston: Little Brown and Company, 1959, 370 pp.

The first edition of this book was written in 1947. The many changes in public health since the original writing prompted the author to complete this second edition. Our changing society has made for a shifting of emphasis in the incidence of disease. This has caused rapid advances in treatment and in public health.

Water purification and other aspects of environmental sanitation are not covered in this volume since the author feels these areas are more of the concern of the public health engineer and other experts. However, a chapter on "Some Aspects of Environmental Hygiene" deal with air pollution, radiation, safe food, and adequate housing.

A significant feature of the book is the space devoted to the care of the elderly.

Other chapters deal with prevention of disease, health education, medico-social services, home safety, world health, and others.

The book is of value to those interested in public health and those occupational therapists who do homebound work.

—Lester M. Brower, M.A., O.T.R., R.P.T.

PRINCIPLES AND TECHNIQUES OF PSYCHIATRIC NURSING (Fifth Edition). Ingram, Madelene Elliott, R.N. Philadelphia and London: W. B. Saunders Company, 1960, 479 pp.

From 1939 to 1960, this author has contributed five text books to the psychiatric nursing profession. The present edition brings up to date information on the currently wide use of ataractic drugs in the treatment of mental illness, an explanation of the trade names for numerous drugs, when and how they came into use, and the administration of nursing care. New material has also been included dealing with the subject of "philosophy-psychology-psychiatry"; the "dynamic" approach has been broadly developed.

Occupational and recreational therapy is covered in a detailed and useful manner with over fifty pages devoted to the subject. The book is very comprehensive in dealing with techniques for all phases of patient care—custodial, motivational, physical, and mental. It should be most valuable to both the instructor and the student. "It is highly recommended for students preparing for their state boards," this reviewer has been informed by a nursing educational director.

—Bertha J. Piper, O.T.R.

CLASSIFIED ADVERTISING

Classified advertising accepted for POSITIONS WANTED and POSITIONS AVAILABLE only. Minimum ad $4.00 *for* 3 *lines, each additional line* $1.00. (*Average* 56 *spaces per line.*) *Classified display, boxed,* $5.00 *per column inch. Copy deadline first of each month previous to publication.*

POSITIONS AVAILABLE

Occupational therapist wanted for full time position in accredited psychiatric hospital. Salary based on experience, minimum $4200.00 annually. Mrs. Heide F. Bernard, Executive Director, Hall-Brooke Hospital, Greens Farms (Westport—1 hour from New York by train or car), Connecticut.

Registered occupational therapist II—supervisory position. Planning and directing program for 2,500 bed mental hospital. Salary range $4,452-$5,460. Three weeks paid vacation. Two weeks sick leave, legal holidays. Social security and retirement system. Group life insurance. Situated in capital city with excellent cultural and recreational facilities. Write for details and application to Mr. E. H. Tilley, Personnel Officer, Dorothea Dix Hospital, Raleigh, North Carolina.

Occupational therapist in private psychiatric hospital (O.T.R.). Work includes recreation and entertainment as well as the occupational therapy program for both men and women. Maintenance is provided. Salary open. Apply to Clifford D. Moore, M.D., Medical Director, Stamford Hall, Stamford, Connecticut.

Immediate opening for staff therapist in rehabilitation hospital treating children and adults. Addition to be completed early this summer includes complete new OT department. Current staff of five will be increased to meet greater in and out-patient capacity. Progressive personnel policies. Salary commensurate with experience and training. Location ideal for cultural interests and all sports. Further information and attractive brochure furnished on request. Apply to Administrator, Sunnyview Orthopaedic and Rehabilitation Center, Inc., 124 Rosa Road, Schenectady 8, New York.

Wanted: registered occupational therapist to head department, 60 bed hospital for NP services. Salary open —5 day week. Paid vacation, sick leave, legal holidays, group hospital and life insurance. Apply Peachtree Hospital, 41 Peachtree Place, N.E., Atlanta 9, Georgia, giving qualifications and experience.

Immediate openings for occupational therapists in 489 bed general medical and surgical hospital with bed allocation for PM & R, NP and TB services. Two well equipped clinics, active physical medicine research program, affiliation with Duke University Medical Center. Career civil service with liberal sick leave, annual leave, retirement benefits. Salary begins at $4040 for new graduates, $4980 for experienced therapists. Write Personnel Officer, VA Hospital, Durham, N. C.

Opportunities for professional growth and advancement with excellent medical supervision in adult and child psychiatry programs—in-service training, participation in team conferences. OT student affiliation center. Openings for staff OT and supervisor of OT in expanding program of modern 225-bed acute, intensive treatment, research and teaching psychiatric hospital, located on campus and affiliated with Indiana University Medical Center. Swimming pool, tennis courts and recreational facilities on campus. Excellent salary, holiday, leave and retirement plans. Blue Cross-Blue Shield available. Initiative and resourcefulness considered for inexperienced therapist, registered or eligible for registration. Additional consideration given therapist with acceptable professional experience. Contact: Virginia L. Caskey, O.T.R., Coordinator of Activity Therapy, Larue D. Carter Memorial Hospital, Indianapolis 7, Indiana.

Growing department wants staff therapist interested in physical disabilities and geriatrics. Excellent salary, liberal personnel policies, vacation. Write Miss Bettilou Purrman, O.T.R., St. Nicholas Hospital, Sheboygan, Wisconsin.

Full time OTR to work with handicapped children and adults in out-patient clinic. Minimum starting salary $4,000 with credit given for previous experience. To apply write: Mrs. Jane B. Shapley, Executive Director, Clinic for Cerebral Palsied & Handicapped, P.O. Box 253, Ithaca, New York.

Immediate opening: the service of an occupational therapist will be limited to the patients of the new thirty-eight bed psychiatric unit and eighty bed geriatric unit of this three hundred and forty bed general hospital. An adequate budget is allowed the therapist interested in developing this new service. The salary classification is attractive. Write: Administrator, Allen Memorial Hospital, Waterloo, Iowa.

Wanted: registered or registration eligible OT's to work in intensive treatment units within a 3000 bed psychiatric hospital. Units include teenagers, a 90-day unit, 3 "progressive wards" units & geriatrics. Team approach to patient treatment. Contact Miss Marguerite Wilson, O.T.R., Cleveland State Hospital, Cleveland 5, Ohio.

Registered occupational therapists wanted. 1540-bed NP hospital. Community of 8000, 35 miles from Des Moines, Iowa. Career civil service positions. Liberal employee benefits. Salary $4040 or $4980 depending on experience. Write Chief, Personnel Division, VA Hospital, Knoxville, Iowa.

Large, progressive teaching institution in Cleveland, Ohio, offers a challenging staff position with 5 day, 40 hour week, exceptional benefits, modern facilities, and competitive salary. Reply Box 90, American Journal of Occupational Therapy, 3514 N. Oakland Ave., Milwaukee, Wis.

Wanted: Registered occupational therapist II (director), salary $4,680 to $5,824. Occupational Therapist I, salary $3,900 to $4,888 depending on qualifications. Relatively new department with growth possibilities. Paid vacation, sick leave, legal holidays, excellent retirement system, group life insurance. Apply: Peter W. Bowman, M.D., Supt. Pineland Hosp. & Training Center, Box C, Pownal, Maine.

Immediate openings for OTR's, director and assist. dir. of OT dept. in 230 bed intensive treatment state psych. hosp. New air conditioned bldg., new equip., 40 hr. week, civil service, starting salaries of $400 & $315 respectively, with annual increases. Total therapy program with team approach. Teaching and research opportunities. Male or female therapists, US citizenship required. Contact Supt., Woodside Rec. Hosp., Youngstown, Ohio.

OTR to head OT department in 350 bed general hospital. Paid vacations and holidays, sick leave, 40 hour week. Salary open—depending on education and experience. Write: L. E. Thompson, Personnel Director, St. Rita's Hospital, Lima, Ohio.

Opening for occupational therapist to head the department in a residential center. Work mostly with cerebral palsied but some with other crippled children. Modern air conditioned facility. Work on quarter system with vacation between quarters. Excellent insurance and retirement program. Salary open. Must be registered or subject to registration. Refer inquiries to Thomas B. Dungan, Director, Mississippi Hospital-School, 777 Lakeland Drive, Jackson, Mississippi.

Staff position for registered occupational therapist or eligible graduate, rehabilitation dept. of large, modern tuberculosis hospital. Pleasant suburban location with good transportation, shopping and recreational facilities. 40 hour week, paid vacation and holidays, liberal cumulative sick leave, retirement plan. Full maintenance available at reasonable rate. Opportunities for further education in local universities. Write: Director of Rehabilitation, Sunny Acres Hospital, Cleveland 22, Ohio.

Registered occupational therapist with experience and interest in physical disabilities. Beginning salary without experience, $355 per month—higher with experience. Complete benefit program. For further information write: Personnel Section, Mayo Clinic, Rochester, Minnesota.

Immediate placement: male or female staff occupational therapist (registered or eligible for registration) opportunities in psychiatric and rehabilitation areas working in conjunction with physical therapy. 300 bed J.C.A.H. general hospital completely new modern and excellent facilities, 40 hour work week, good working conditions and liberal personnel policies. Salary commensurate with experience. Apply Personnel Department, Saint Joseph's Hospital, South Bend, Indiana.

Northern Wyoming—immediate opening in new rehabilitation center. Salary $4,224 for 1 yr. experience with increase of $192 for each additional year. Two weeks vacation plus 1 professional meeting and 1 educational course yearly. Major medical plan. Challenging position for OTR with pioneer spirit in treatment media, organization and public education. Contact Patricia Kelsey, OTR, Gottsche Rehabilitation Center, Thermopolis, Wyoming.

Occupational therapist required as chief lecturer in occupational therapy at the University of Manitoba. New school opening fall term 1960. Salary $6000.00 to $6800.00 depending on qualifications and experience. Further particulars from the Director, School of Physiotherapy and Occupational Therapy, 1654 Portage Avenue, Winnipeg, Canada. Applications with two testimonials should be airmailed to the same address as soon as possible.

Immediate opening: therapist for new 15 patient psychiatric unit in large medical center. Possibility for initiative in organizing and developing dynamic OT program. Apply Mrs. Dorothy Weiser, O.T.R., P.H.5-532, Columbia Presbyterian Medical Center, 622 West 168 Street, New York 32, N. Y.

Wanted: OT, AOTA member, for ideally equipped OT dept. in CP center, three weeks paid vacation, liberal holidays. Salary based on experience. Minimum $4,600. Contact V. J. Privitera, Director, CP center, 808 Crockett, Amarillo, Texas.

Openings for staff OTR's in psychiatric department of private general hospital. New department. Three units, totaling 62 beds. Day patient program, student training center. Three weeks paid vacation, sick leave, legal holidays. Apply to: Frances Rizzo, O.T.R., Director of Occupational Therapy, Department of Psychiatry, Presbyterian-St. Luke's Hospital, 1753 W. Congress St., Chicago 13, Ill.

Male or female staff registered occupational therapist in hospital-school for educable severely physically handicapped children. Broad emphasis includes physical, social and emotional aspects. For information, write Virginia Reeves, Illinois Children's Hospital-School, 2551 N. Clark St., Chicago 14, Ill.

Immediate opening for one staff occupational therapist, adult unit, and pending openings for one supervisor of occupational therapy, adolescent unit, and for one female staff recreational therapist to work with adults and adolescents. Progressive psychiatric center associated with University of Michigan Medical School. Four units for intensive treatment of children, adolescents, and adults, with occupational and recreational therapy supervisors on each unit. Student affiliation center. Generous personnel benefits; salary commensurate with experience. Address communications to Personnel Department, University of Michigan Medical Center, Ann Arbor, Michigan.

Staff occupational therapist—for well-organized expanding department in a progressive psychiatric hospital located within the city limits of Lexington, Kentucky. University of Kentucky and a new Medical School offer many educational and cultural advantages. Will consider recent graduate. Beginning salary $4296 with promotional possibilities to $6048. Very liberal employee benefits. For further information contact: Mrs. Frances M. Jonakin, Occupational Therapy Consultant, Eastern State Hospital, Lexington, Kentucky.

Occupational therapist for small private school for crippled children. Salary based on experience. Eight weeks paid vacation. Well-equipped department. Friendly atmosphere, in beautiful Berkshire Hills. Write Miss Florence McConahey, Coolidge Hill School, Pittsfield, Mass.

Occupational therapist, beginning August 29, work with handicapped children. Modern, one story air conditioned UCP center, city 100,000, near lakes. Program includes 3 disciplines, education. Liberal vacation—2 wks. Christmas, 1 wk. Easter, 3 wks. August, plus regular holidays. Salary dependent on experience. Write UCP Center, 1201 8th St., N.W., Cedar Rapids, Iowa.

Occupational therapist registered: 2 vacancies at Grasslands Hospital—one psychiatry, one geriatrics and medical services. Beginning salary $4710 with annual merit increases to $5290. Liberal personnel policies. Apply Personnel Office, Grasslands Hospital, LY-2-8500, Ext. 61.

OCCUPATIONAL THERAPISTS for California's progressive programs in state mental hospitals and for physically handicapped children in special schools. Opportunities for imaginative and resourceful therapeutic activities. Eligibility for registration with the national registry of the American Occupational Therapy Association is required. No experience is needed to start at $436 a month. Positions in schools under the Crippled Children Services program are open also to experienced occupational therapists at $481 a month. Attractive employee benefits. Secure details from State Personnel Board, 801 Capitol Avenue, Sacramento 14, California.

Staff therapist for rapidly expanding department in out-pt. clinic. Here is an opportunity to acquire experience in all phases of the field from therapy in geriatrics, functional therapy with children to prevocational evaluation with middle age citizens. 35 hour week, liberal vacation and paid holidays. Located in beautiful section near Long Island Sound, near Univ. of Bridgeport campus, 1½ hour from N.Y. Contact: Miss Deborah Mund, Senior OT, Conn. Soc. for Crippled Children and Adults, Bridgeport Chapter, Inc., 85 Park Ave., Bridgeport, Conn.

Positions available: Supervisor requiring registration and at least two years experience. Staff therapist requiring registration or registration eligibility. These positions are now open in an accredited dynamically oriented psychiatric teaching hospital offering opportunities to do research, teaching and to work with other disciplines in treating the acute emotionally sick, ages 12 to 60, within a three hundred bed hospital. For further information contact Miss Inez Huntting, O.T.R., Director Occupational Therapy, Cleveland Psychiatric Institute and Hospital, 1708 Aiken Avenue, Cleveland 9, Ohio.

Staff OT positions in new, modern, 1100 bed GM&S hospital with TB allocation, affiliated with N. Y. Medical College. Large, well equipped dept. with immediate placement in areas of physical disabilities and pulmonary disease. Seven hour day, five day week, four weeks paid vacation, eleven holidays, twelve days sick benefits, shorter summer hours. Salary $4250 per annum. Write: Miss E. A. Palmer, O.T.R., Metropolitan Hospital, 1901 First Ave., New York 29, N.Y.

Co-ordinator of activity therapy—Salary range: $525 to $625 per month. Minimum requirements: graduation from an approved school of OT, registration, and five years experience in psychiatric occupational therapy, of which two years should have been in a supervisory capacity and one year in an administrative capacity, such as supervisor or director of a psychiatric OT program. Full maintenance including apartment and commissary privileges available. Apply: Ralph B. Cary, Personnel Officer, Logansport State Hospital, Logansport, Indiana.

'Occupational Therapist I: occupational therapist position for a male at the institution for the mentally ill. Requires graduation from a school of occupational therapy approved by the Council of Medical Education and Hospitals of the American Medical Association, including or supplemented by one year of supervised occupational therapy work experience in a recognized agency or institution. Salary $403.00 per month. Apply: Mrs. Loretta Fukuda, Recruiting & Examining Supervisor, Hawaii Personnel Services, 825 Mililani St., Honolulu 13, Hawaii.

Registered occupational therapist wanted for 1,000 bed general medical and surgical hospital with bed allocation for TB and NP services. Affiliated with State University of New York Downstate Medical Center. Positions available at GS-5, grade range $4040-$4940 p.a. through GS-8, $5470-$6370 p.a. Write to Manager, Veterans Administration Hospital, Brooklyn 9, New York.

Registered occupational therapist for chronic disease (all ages and geriatric program). 290 bed hospital. Starting salary $4,712.50. Two weeks vacation, sick leave, legal holidays. Social security and retirement system. Make application to: Mr. Paul R. Bishop, Genesee County Hospital Facilities, G-4562 Flushing Road, Flint, Michigan.

Registered occupational therapist to work in a small center for physically handicapped children with PT, ST, and school. Salary commensurate with experience. Center open during school year only. Write resume of education and experience to Dutchess County CP Clinic, 67 South Randolph Avenue, Poughkeepsie, New York, Att: Mrs. Nelson. Position available early in September, 1960.

Occupational therapist ($6,000) in a demonstration (OVR Grant) aimed at up-grading the care of patients in nursing homes through the establishment of occupational therapy assistants. Training programs for specific occupational therapy work in nursing homes will be established and supervision given to work in nursing homes. Apply W. J. Peeples, M.D., Montgomery County Health Department, Rockville, Maryland.

Available about September first: Position for occupational therapist in new day hospital program of general hospital psychiatric service. This is a small unit with an active program planned. Minimum $4600—higher with experience. Also, immediate opening for occupational therapist on GM&S service in physical medicine department. Paid Blue Cross, insurance, 3 week vacation, sick leave, and holidays. Contact: Miss Louise A. Rathbone, Chief OT, The Roosevelt Hospital, W. 59th St., New York, N.Y.

Registered occupational therapist needed for Veterans Administration Center—570 bed GM&S hospital and 1,250 bed domiciliary. OT staff consists of 4 therapists and 2 OT assistants. Starting salary—recent graduate with little or no experience $4040; experienced therapists $4980. Additional benefits—annual and sick leave, retirement system and insurance. The Center is located on historic Hampton Roads, Virginia, in the city of Hampton, close to Norfolk and Virginia Beach. For application forms or further information, write or call Personnel Division, VA Center, Kecoughtan, Virginia.

Registered occupational therapist for modern and well equipped Easter Seal center. Program includes handicapped children and adults on an out patient basis and a work evaluation project for cerebral palsied adults, all under medical supervision. Five weeks paid vacation and liberal personnel policies. Salary open. Write Donald H. Gerdom, Executive Director, Easter Seal Center, 2920-30th Street, Des Moines 10, Iowa.

Staff OTR, new grads eligible, $360-440, full maintenance $40, liberal sick, retirement, and vacation benefits under C.S., walking distance to Capitol. O.T.S. program. Team approach, adjunctive therapies coordinated under psychiatric director. Opportunities for initiative, prof. educ. Robert Miller, O.T.R., Oregon State Hospital, Salem, Oregon.

Immediate opening for OTR in a progressive teaching hospital for chest diseases located in university medical center. Comprehensive OT program within interdisciplinary rehabilitation department. Used as clinical practice center by 8 occupational therapy schools. Paid vacation and holidays, sick leave, retirement plan. Will consider recent graduate. Apply to: Mrs. Jean Luppens, Director of Rehabilitation Department, Ohio Tuberculosis Hospital, 466 W. 10th Avenue, Columbus 10, Ohio.

Immediate opening for registered occupational therapist with experience to be incharge of OT department in 225-bed Catholic general hospital. Program includes day care center for mentally retarded children. Starting salary $340.00. 5-day, 40-hour week. Benefits include 4 weeks annual vacation, sick leave, medical insurance, retirement plan. Write Personnel Dept., St. Francis Hospital, 2260 Liliha St., Honolulu, Hawaii.

The Winfield Hospital, a 71 bed tuberculosis hospital closely affiliated with a large general hospital, has an opening for a director of occupational therapy. Our program emphasizes rehabilitation. Excellent relationships with other departments. Personnel practices include one month vacation and liberal sick leave. Salary commensurate with experience. Write to Mrs. Marie L. Novak, Executive Director, Winfield Hospital, Winfield, Illinois.

Wanted: chief of occupational therapy department in children's rehabilitation center—university affiliation—opportunity to work as member of team in evaluation and treatment program for all types of neuromuscular handicaps including large amputee group. Also active in teaching program. Salary open. Write Dr. William Georgi, Physiatrist, Children's Rehabilitation Center, 936 Delaware Avenue, Buffalo 9, New York.

Immediate opening for occupational therapist in modern tuberculosis hospital operated by the State of Ohio. Starting salary $3780 with yearly increases up to $4560. Paid vacation, holidays, liberal sick leave cumulative up to 90 days, state retirement plan, and 40-hour week. Excellent recreational facilities. Write to: Director, Southeast Ohio Tuberculosis Hospital, Box 359, Nelsonville, Ohio.

Position open, first of September for an occupational therapist in crippled children's school. Operates under local school district. Same vacations. Contact: Mr. E. A. Durbahn, Superintendent Worthington Public Schools, Worthington, Minnesota.

Immediate opening for OTR in crippled children's center. Work primarily with children 3-8 years old, CP's, brain-damaged and accident patients. Coordinate program with speech therapy and nursery school program. Job also includes homebound OT services in community. Metropolitan center of 280,000. Excellent physical medicine and rehabilitation center and university located in city. Salary $4,200-$6,000 depending upon training and experience. Write Crippled Children's Center, 1228 Hamilton Boulevard, Peoria, Illinois.

Position as assistant professor open at the University of Southern California. Candidate must have a master's degree and be interested in teaching in the field of psychiatry at undergraduate and graduate levels. A second similar position may be available in the area of physical disabilities. For further information write to: Miss Angeline A. Howard, O.T.R., Head, Department of Occupational Therapy, University of Southern California, Los Angeles 7, California.

Dundee Royal Mental Hospital (760 beds). Assistant occupational therapists (2) required for large department in above hospital, which is the psychiatric teaching hospital for the University of St. Andrews. The hospital offers valuable pioneering and research experience in occupational therapy, using a wide variety of treatment methods. Good working conditions, and salary in accordance with Whitley Council Scale. Applications, stating age, qualifications and experience, with names of two referees to the Physician Superintendent, Dundee Royal Mental Hospital, Liff, Dundee, Scotland.

Experienced or inexperienced. Good personnel policies. 37½ hour work week. Salary scale, $4400 to $5200. Crossroads is located in a beautiful new building, well equipped. Research opportunities. Write Roy E. Patton, Executive Director, Crossroads Rehabilitation Center, 3242 Sutherland Avenue, Indianapolis, Indiana, or call WAlnut 6-2481.

Positions available (2): chief occupational therapist, staff occupational therapist: for 100 bed rehabilitation center. Excellent possibilities for professional growth; graduate education available; good working conditions and liberal benefits. Salary dependent upon experience. Inquire: Executive Director, Home for Crippled Children, 1426 Denniston Avenue, Pittsburgh 17, Pennsylvania.

OTR to head department in 65-bed specialized children's hospital, a supplemental facility of the University of Oklahoma Medical Center: orthopedic, pediatric, and plastic service. Salary commensurate with experience and training, $4,200-$5,520; annual and merit increments. Excellent retirement plan; paid vacation and sick leave; allowance on expenses and time off, with pay, while attending professional institutes and conventions. Write Administrator, Children's Convalescent Hospital, Box 698, Bethany, Oklahoma, or phone WH 9-5611.

Position available for staff therapist in out-patient center for cerebral palsied children. Treatment emphasis on children of pre-school age. Program includes nursery school, class for mentally retarded children, adult workshop. Chest agency. Pleasant surroundings, competent and congenial staff. Four weeks summer vacation, generous Christmas holiday, social security and retirement plan, Blue Cross and Blue Shield health insurance, sick leave. Salary dependent upon experience. Interview arranged at our expense. Write Miss Ruth Hadra, O.T.R., Chief Therapist; or Mr. John J. Evans, Executive Director, United Cerebral Palsy, 3601 Victory Parkway, Cincinnati 29, Ohio.

OTR needed in pediatric hospital for patient treatment and supervision of students. Write: Personnel Office, Children's Hospital, 219 Bryant Street, Buffalo 22, New York.

Occupational therapist wanted immediately for the Cerebral Palsy School-Clinic of Northeast Louisiana. Our school is operated much as a public school with occupational, physical and speech therapies included. The occupational therapist will be required to work from approximately 8:00 a.m. to 4:00 p.m., five days a week. The therapist will have practically no duties to perform other than occupational therapy. Salary will be based primarily on training and experience and will be discussed with the individual applicant. Write James S. Rutledge, Administrator, Cerebral Palsy School, Route 3, Monroe, Louisiana.

OTR's (3) wanted for rehab. unit of 600 bed general hospital and public home infirmary. Starting salary $4250, 4 week vacation, all holidays, sick leave, retirement plan, six hour day for 3 summer months. Write H. Brod, Coney Island Hospital, Ocean Parkway, Brooklyn 25, N.Y.

Opening for coordinator of volunteer services, N.H. State Hospital, Concord, N. H., in the dept. of OT. Program well established and closely related to occupational therapy but serving entire hospital. Applicants must be college graduates with some experience in community relationship and an interest in the problem of mental illness. 3 weeks vacation, 3 weeks sick leave, as well as other fringe benefits. Good maintenance available on hospital grounds at nominal cost. For application forms and further information write Eileen Dixey, O.T.R., Director of Occupational Therapy, N.H. State Hospital.

A few staff therapists positions are still open for a chronic disease (all ages) and geriatric program in a 2000 bed city hospital and home affiliated with New York Medical College. Positions are available in children's rehabilitation (cerebral palsy), adult rehabilitation, hospital-home maintenance program, home care and special studies. Student training program. Seven hour day, five day week, four weeks paid vacation, eleven holidays, twelve days sick benefit, six hour day for summer months. Salary $4250-$5330, (annual increments $180). Write Mrs. Carolyn Aggarwal, O.T.R., Bird S. Coler Hospital and Home, Welfare Island, New York 17, New York.

Registered occupational therapists: Positions available in large AMA accredited state mental hospital for sr. occupational therapists, salary range: $4750-6178, annual increment $238; or staff occupational therapist, $4309-5599, $215. Well OT oriented administration. OT clinical training program projected. Must be college graduate and registered or eligible for registration. Forty hour week, paid vacation, holidays and sick leave. Low cost maintenance available. If interested, please contact John E. Ellingham, Personnel Director, Ancora State Hospital, Hammonton, N. J.

Conn. state chronic disease hospital. Two OTR positions immediately available in 275-bed hospital in Hartford vicinity. Living quarters available. Civil service benefits. Salary range $3840-$4740. Contact Supt., Cedarcrest Hospital, Newington 11, Conn.

Occupational therapy supervisor—will have full charge of OT department in State Psychiatric Institute with a new building and an expanding program. Salary $4800 to start, with automatic increases to $5760. Sick leave, retirement plan, paid vacation and holidays, 40-hour week. Write C. O. Ranger, M.D., 3009 Burnet Avenue, Cincinnati 19, Ohio.

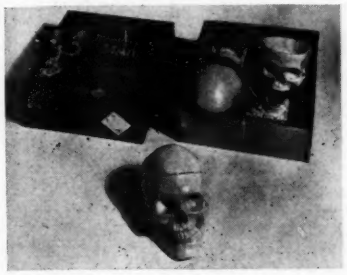
Immediate openings—registered occupational therapists. Large PM&R service with active supervision and guidance of psychiatrist. Clinical training program. 2400 bed psychiatric hospital. Career positions with opportunities for advancement. Attractive fringe benefits. Starting salary—six months experience or graduation in upper 25% of class—$4980. Starting salary—no experience—$4040. Write: Personnel Officer, VA Hospital, Northport, L.I., New York.

Positions open for staff therapists in progressive well-equipped OT department of largest private mental hospital (750 beds) in USA. Well-rounded program includes both workshop and ward classes. Paid annual vacation and sick leave, laundry and maintenance provided. Pleasant working conditions, beautiful surroundings. Write to Dr. J. Butler Tompkins, Superintendent, Brattleboro Retreat, Brattleboro, Vt.

Opening for registered occupational therapist in 500 bed modern hospital. Three weeks paid vacation, 40 hour week plus sick leave, holidays, free life insurance and group hospitalization. Salary open. Contact Personnel Director, Wesley Hospital and School of Nursing, 550 N. Hillside, Wichita, Kansas.

Have You Tried?

A plastic life-size human skull, in natural bone color and anatomically accurate, is a new low-priced scientific study aid. The skull, sold commercially as "THE THINKING MAN," is manufactured in kit form or fully assembled by Superior Plastics, Inc., 426 N. Oakley Blvd., Chicago, Ill. A spring-action lower jaw accurately simulates lifelike movement, and the cap of the skull is removable for demonstration and study of its interior. A unique multi-dimensional brain model has been developed as a separate unit to fit into the cranial cavity. The skull comes complete with display stand and anatomy chart. A dust-proof plastic cover is available as an accessory.



A macabre activity could be planned for Hallowe'en by ordering the kit that needs to be assembled. The doctors on the staff would appreciate the assembled job for use in their lectures. Cost of the kit is $5.00. (The assembled unit sells for $8.00.) Order an extra one for your own department seminars.

* * *

The arm sling suspension unit for a wheelchair helps prevent deformity and encourages activity. It provides excellent support for a patient's arm to facilitate self-feeding, exercising and ADL. Fits any tubular wheelchair with quickly installed bracket.

The overhead support rod is easily removed when sling is not in use. Sling assembly is adjustable to any position along the overhead stainless steel rod. Comfortable leatherette slings adjust to any patient—adult or child. The sling is distributed by Rehabilitation Products, a division of American Hospital Supply Corp., 2020 Ridge Ave., Evanston, Illinois.

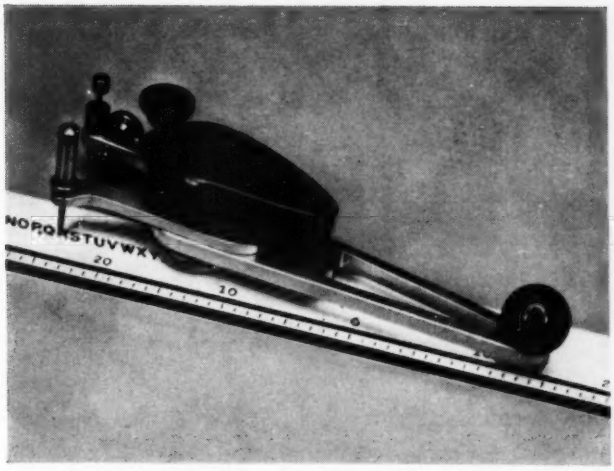
* * *

Leaf patterns, called Flex-O-Rubber Leaves, are recommended by Irene Jamison, O.T.R. She has found them to be ideal for occupational therapy as they produce fairly quick results to motivate patients who feel they have no talent for creative work. The patterns are available from Starola Ceramic, 415 South Hawthorne Ave., Sioux Falls, So. Dakota.

* * *

Have you tried Elmer's glue in mosaic tile work? It is easy to handle, sticks like mad after it sets, dries clear, and comes in squeeze plastic bottles. You can buy Elmers in quarts and gallons to refill your bottles to save you money. Distributed by S & S Arts & Crafts of Colchester, Conn.

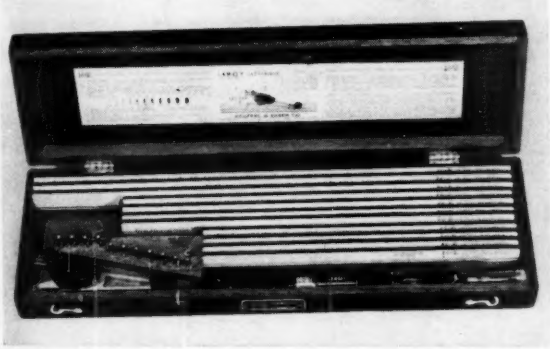
Controlled lettering... an important therapeutic tool



LEROY® and DORIC® Lettering Sets – used by engineers and artists throughout the world – can be of exceptional value in occupational therapy.

These Keuffel & Esser Co. sets apply a principle of "controlled" lettering. Outlines on a template are followed with a scriber to produce numbers, letters and symbols exactly. The technique is extremely quick and easy to learn, yet the results produced are neat and professional.

With DORIC, templates are standard. The more comprehensive LEROY sets are available with a large variety of alphabets, type faces, and special designs. OT's may even design their own LEROY templates, for completion by K&E.



LEROY Lettering Set by K&E comes neatly packed in polished mahogany case, includes assortment of templates and pens, adjustable scriber, scriber stand, lead clutch with leads, socket holder, pen holder and ink cartridge.

Work with these sets requires a minimum of muscle strength, grasp and coordination, making them ideal for the physically handicapped of all ages. Since the arm movements required are mainly limited to the forearm and wrist, the sets are also valuable in tubercular and chest disease cases where arm motion must be restricted. OT's working in psychiatric fields will also find controlled lettering a valuable aid.

LEROY lettering is widely used in engineering and commercial arts. As such, the K&E sets are well suited to pre-vocational exploration, and rehabilitation.

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Script	*ABCDEFGHabcdefghi*
Slant lettering from straight template	CDhol2 DESabcd
Special designs	
Russian Alphabet	АБВГДЕЖЗИІКЛМ

Some of the many templates available for the versatile LEROY Kit. Other type faces, letter sizes (up to 2" high), foreign languages, special designs, etc., may be furnished to your own specifications on request.

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